The Harveian Lectures

ON

COMMON NEUROSES, OR THE NEUROTIC ELEMENT IN DISEASE AND ITS RATIONAL TREATMENT.

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LECTURE III.

WE must now pass from the neuroses of the heart and lungs to take up those that show themselves in the abdominal viscera, and there are several that supply much interesting material bearing on their rational treatment. I shall take in order the stomach, the intestine, the kidney, and the liver. I have much to say about the stomach and the rational treatment of its diseases, for I believe they are often treated most irrationally; and let me take first the common, very common, ailment of flatulent dyspepsia. And here at once I suspect that if anyone who has devoted himself to the treatment of stomachs thinks me worthy of any attention, he will at once fall foul of me when he finds that I am going to have my say on this subject in *general*, so to speak. "What can he know about dyspepsia when he talks of it as an entity that knows no differences of form?" Well, I have often said that although there are all sorts of different dyspepsias elaborated out of the heads of individuals, if I were going to write a book on indigestion, I should first devote myself to a volume on diseases of the nervous system. Surely I cannot be wrong when I make this statement, that of the numbers of dyspeptics that fill the doctors' lists the greater proportion by far are neurotics in one form or another. It is really no great exaggeration to say that there are only two forms of indigestion: that produced by over-eating and drinking, and that due to a failure of nervous power. There are other conditions that are met with as rarities, but these who knows anything about? For instance, there is an acute condition originating in some indiscretion in diet, in which the stomach takes to forming sulphuretted hydrogen. I have seen three or four such cases, but if I try to find out anything about it the authorities have very little indeed to tell. Then we talk about acid dyspepsia and atonic dyspepsia, as if any dyspepsia were other than acid, and, from my point of view, as if atonic dyspepsia were necessarily something different. Gouty dyspepsia is another term in frequent use, but it is no different; it is often enough a little of both the others, and sometimes the indigestion of over-eating and over-drinking as well. Nor is the classification, according to morbid anatomy, much better, for here the observer talks of catarrh of the stomach as if the stomach easily catarrhed; whereas we know as certainly as we know any fact of physiology or medicine that of all the multitudinous sins of commission that are done to its would-be detriment there is happily not one in a hundred, if so many, to which the stomach deems it necessary to turn a hair. Were it otherwise the human race would not last out two or three generations. No! If there is one thing that is certain, it is that the stomach is an organ that has been trained by centuries of custom, and by slow processes of evolution, to a condition of hardihood that endows it with the special attribute of comparative callousness, and within limits, and *mutatis mutandis*, I would as soon talk of catarrh of a bird's gizzard. But if, as is assuredly the case, the stomach will stand all this hard work, and still come up smiling, it must needs be supplied with an amount of "go"—in other words, of nervous energy—to enable it to do its work; and it is just this supply that, in this era of high civilisation, is often and often cut short. There is a sort of action abroad that would seem to say: "Oh! anything is good enough for the stomach." Men go into the City, for example, and, beginning at 9 A.M., go on till 6 or 7 P.M., and often enough bring home their business worries with them, their brains being all the while in a state of turmoil. In the midst of this they eat and drink, and ask their stomachs to digest. But if they have exhausted their nervous supplies—and more than exhausted, have overdrawn their capital of this, as they often have to no inconsiderable extent,—where is the stomach to get its motive power? Take, again, the neurotic woman, in any of the many forms in which she presents herself to your gaze. No lecturer, gifted even with the most consummate art of word painting, could depict the many ways in which women of this sort consume their nervous energies; but consume them they certainly do, and they constantly find themselves in the same case, and their stomachs find themselves called upon to perform the impossible task of making bricks without straw.

I assert without any fear of contradiction that this is *the* indigestion of the present day. How do we treat it, and what is its rational treatment? Well, I suppose, it is ten to one in favour of the patient getting a little soda and bismuth, and perhaps a little gentian or calumba in addition. If the patient will run to it, he may take some rhubarb and magnesia instead, and generally, I believe, it must be said that he at first leaves his doctor's door well satisfied that he has got his money's worth. But time goes on, he has consumed his appointed potions (most of these people take medicines well), and he does not feel any very sensible relief from the vagaries of stomach discomfort to which he has been subjected; so back he goes to the doctor, and now probably a few drops of mineral acid and nux vomica are ordered, and this time it is precisely prescribed, perhaps, to be taken an hour before meals, because—well, because—well, I will leave that to the Seers. But time again goes along, and our dyspeptic begins to have qualms whether he is placing his money rightly, and before long he is to be found at somebody else's door, and No. 2 has *his* turn; and so on to Nos. 3 and 4, up to the 12th. If the patient, male or female, be a particularly bad case, he or she will produce in the course of consultation with, say, the tenth best physician on stomachs that exist in the metropolis, a bundle of prescriptions that for thickness may well make his face turn pale and his eye involuntarily seek the clock, while his ears will tingle, I think, with shame that any human being can be so bereft of common sense as not to have got his cure or let it alone ere it has come to this. Will anyone say this is an overdrawn picture? I have seen it too commonly not to know. There are two things that I very generally do on such occasions: one is to indulge in a very short-lived regret that I entered the medical profession, and the other to ask the patient to have so valuable a manuscript bound in calf. But why do things come to this pass? Are we only to have a laugh at the ignorance of the uninstructed? Is there no beam in our own eye? I think there is a very big beam. And it is this, that we are much too fond of giving a prescription because the uninstructed want it, and we do not ask ourselves the question, Is a *drug* the right treatment here? Will it ever come to pass that the public will pay us for our brains, and receive an order for physic as an evil, which, if it must be, must be? But I am wandering from my subject. I do not wish to convey that in these cases of indigestion we can do without drugs, but I do mean to convey most urgently that they are not *the* treatment. It does not follow because a man or a woman has dyspepsia that bismuth and soda are forthwith to be shot into his or her stomach. The great majority of the dyspeptics of the present day are so because their nervous power has run down, or has been incontinently consumed in other directions, without any regard for the needs of the stomach. The first and foremost treatment in these cases is to take what steps can be taken to lessen the tax upon the nervous centres, and to tone up those that are run down. Often would I, were it not a mockery, write on the prescription paper of many a hard-worked man in the City toiling for his bread-and-cheese: Recipe—£500 a year and an eight-hour day. Often and often, for the woman who frets her nerve force into useless fritters, "An occupation that shall give you freedom from yourself." Could one but give these things away there would be no occupation for us in the way of treating indigestion, and it is the hardest part of a doctor's life to feel what he knows to be the right treatment, and yet to be obliged to give a dose of medicine as the nearest approach to the possible. But such *is* our life, and we cannot do otherwise than accept its conditions; but in doing so it falls to me to say that these are cases for tonics and every available means

for invigorating the nervous system, and the remedies I have decried, but have in no way besmirched—for they are good enough in their place—are to come in their proper place, and be only called to our aid to treat symptoms of passing occurrence.

Next, though not quite in order on my list, I will take anorexia, or want of appetite, because it is closely bound up with this subject of indigestion. There is no more common ailment than this, and it is much more common amongst women than amongst men, although it may be found in either sex, and it also is largely the product of our civilisation, and of an improper consumption, or feeble supplies, of nervous energy. Therefore I think the term proposed by the late Sir William Gull of anorexia nervosa a very fitting one. But the cases recorded by that distinguished physician were all cases of extraordinary severity, and it will be in the recollection of some here that such as were narrated in the Clinical Society's Transactions, and by others now and again afterwards in the medical periodicals, have all been remarkable for being in the last stage of emaciation. Interesting as these cases are, they are certainly rare, and I want to extend the term to a much commoner class of cases. I think there can be no doubt that the same disease exactly, but not reaching anything like the same extent, may be seen almost daily by anyone who chooses to see it in his own practice. I read in one of the daily papers the other day this paragraph: "Almost the only failing of the Englishwoman is that she has no touch of gluttony. She does not take an intelligent interest in what she eats. Anything will do, she says. She is incapable of appreciating good cookery, and that is one of the reasons why the English cuisine is fraught with so many terrors." I shall express no opinion about the truth of the latter clause, but I am sure about that of the first. There are hundreds, ay thousands, of women going about who habitually have the smallest of appetites, and they are often enough women of a very active habit of body and brain. Now we all reason from our own experience far more than we do from what we get secondhand. And the familiar experience of everyone here is that when we have gone long without food we soon reach a stage in which we do not care whether we have food or not, and we may easily under such circumstances reject such food as we put into our stomachs. Apply this to the case before us. An individual starts from whatever cause, for the minute it is not necessary to inquire, with a small appetite; she gets tired or overdone, as is very easily accomplished, on the small amount of food that is taken. Meal time comes on, and she finds herself without appetite, and thinking, as most people do, that if the appetite be not there the food cannot be necessary, none is taken, or the meal becomes smaller than the one preceding. So the case goes on, and little by little no food worth the name is taken. Let me give you the day's record of one or two of these cases. A small part of an egg and a finger of toast and a cup of tea for breakfast (this is rather a respectable meal for a case of this kind); for lunch a drachm or so of veal cutlet, no vegetable, or bread or pudding; a cup of arrowroot and brandy at bedtime. A second case: for breakfast, a little potted meat and dried up bread, a cup of strong tea with very little milk; a very small slice of meat and a little vegetable and milk pudding or stewed fruit for dinner; a cup of strong tea, dried up bread, or a biscuit and fruit for tea; milk pudding and a biscuit for supper, and a little soda water at bedtime, and so on.

Now these cases are really very interesting as showing upon how very little life can be sustained; and, indeed, not only sustained, but made to do quite a large amount of active work. Now what happens, what must happen to the stomach under such circumstances? It does not need much labouring; your own common sense will say at once that the stomach, gradually accustomed to diminishing meals, gradually shrinks, and becomes inactive; and inasmuch as the bodily vigour runs at a gradually lessening tide, so it has less and less vigour, until it goes almost to sleep. There are discomforts attending the course of these cases that hasten the process. Their friends notice how little is taken, and all sorts of things are advised and made trial of; and these spasmodic efforts cause to the languid stomach a good deal of pain. The patient then argues within herself that something taken at the last meal has disagreed, and it is cut for ever out of the diet list. Another attempt is made with something else, but with no better success, and out goes this also. Nor does she stop here. So by slow degrees the possibles of her digestion become more and more attenuated. This is nothing more than the common history, not of rare cases, but of any number. What is the use of treating these people only by bismuth and soda and all the usual stomachics? Granted that they have pain, what is the pain due to? It is the result of the state of disuse into which the stomach has fallen and to the irritable state of the nerves which the generally depressed state of body has engendered. The proper method of cure is to first explain to the patient what has happened as the result of the process of gradual starvation, what is the condition and size even to which their digestive apparatus has shrunk; and they must fully understand that it is impossible, or at the least unlikely, that they can be restored to their former selves without a certain amount of discomfort, not to say pain—that their stomachs need to be educated back to a healthy habit, and to be stretched to a more natural size. These, therefore, are the cases, or one class of them, that undoubtedly derive great benefit from what is now generally called Weir-Mitchell's treatment—of stuffing and massage. And it is a treatment that in most cases does these people a great deal of good. They gain weight and are altogether different creatures. I said just now that we might dismiss for the minute the initial fault in these cases; but I have now to say that they are neurotics, almost all of them, and, what is more, they are neurotics of a rather bad type. By this I mean that, although they are submitted to treatment of this kind, and derive much benefit from it, they are exceedingly likely to get back to their old habit again, after a longer or shorter time, and some of them find their way ultimately into the ranks of the insane. This is the fundamental cause, but there is another condition that has, I believe, to share a good deal of the blame. I allude to the most pernicious practice of taking no breakfast. Small eaters, with their last meal taken at seven or half-past in the evening, and probably all digested, so little has it been, many, many hours before morning dawns, and the day's work is then begun on a finger of toast and a cup of tea—sometimes, I have been told, in the exceptionally perverse without even any milk in it. And this to last them till past middle day. How can anyone be expected to have any vigour of mind or body under such circumstances? But I daresay someone will be thinking that the no-breakfast plan is such a common thing that I need not make such a fuss over it. I would not do so if the meal time alone were changed. There is no objection that I know to the chief meals being taken at, say, twelve and six, on the foreign plan, but then the two meals are *taken*, not sniffed at. But I confess to thinking so highly of our English plan of starting with a good solid meal, that a cup of tea at half past seven in the morning, although very nice, is, from a digestive point of view, a mistake, and if I belonged to the band of medical advisers to insurance societies, although I think I should pass many a heart that is now looked at askance, I doubt if anyone would get in as a first class life under my *régime* unless he produced evidence that the volume of his breakfast came within measurable distance of

> "Devilled kidneys and sweetbreads and ducks and green peas,
> Baked sucking-pig, goose, and all viands like these."

It is food, and not medicine, that is the prime need of these people; but I think that it may well be doubted whether this is put before them with all the blunt uncompromisingness and persistency that the occasion and their blindness in the matter require.

Neurotic vomiting is another branch of the same subject, but I shall not discuss it, because it is so well recognised that it rarely fails to receive the appropriate treatment. There is, however, a group of cases in children of which I do not think much is known, so I shall deal with it a little more in detail. I allude to the sudden periodical paroxysmal vomiting of extreme violence that is occasionally seen in children of four, five, and six years or so of age. It goes on for twenty-four, thirty-six, or forty-eight hours; everything, often even water, is returned. The child becomes hollow-eyed and choleraic in appearance, and is, indeed, brought to the very verge of death. In a first attack of this kind it is not unnaturally supposed to be due to some error of diet, although it puzzles the parents often to say what that error may have been. It is, of course, an attack that may very well be set up by an irritant poison in the shape of food, but in these cases the irritant is for the most part

trivial, and similar attacks tend to recur over and over again in the same child. Moreover, they always lead to the most rigid dieting, and yet the attacks recur. I have notes of six or eight such cases, and I cannot but think that the vomiting is of cerebral origin, and not gastritic. At any rate, I do not think such cases should be treated by a too strict diet, for by such means the youthful stomach fails to obtain the requisite amount of experience, and in consequence hereafter takes fright at such trivialities as one currant in a bun. I believe that bromide of potassium and moderate care in diet are more successful. Another common form of neurotic dyspepsia is the condition that is known as *flatulence* simply, and how closely this condition goes with debilitated states of the nervous system is well illustrated by the following case: A man of forty-two, who voluntarily called himself "a wretched nervous fellow," had been dyspeptic for many years, and this makes his heart irritable. His wife died a few months ago, and he got into a very low state. He went to the seaside for seven or eight weeks, and got better; but as soon as he came home again he relapsed. His attacks are very peculiar, in that they always commence with *sleeplessness*, and when this begins he always knows that in three or four days he will be attacked by flatulence and dyspepsia. Having mentioned this man, let me tell of another condition, also in the male, because there seems to be some difference between male and female in this respect. It would almost seem that the flatulence of the male sex is chiefly in their stomachs, and that of women in the bowel. This second case was in a highly neurotic man, who had taken himself out of an honourable calling into that of speculative finance and Monte Carlo-ism. This man came into my room one day, and treated me to the most extraordinary musical performance—his stomach being the bellows, and his mouth the pipe—that I ever remember to have heard. The only advice I deemed it necessary to give him was the very simple command to stop it. And I hope it cured him; for bar his stomach, which was a little mad, he seemed sensible enough.

Now here, again, it often enough happens that such are treated as cases of indigestion, and drugs are put into their stomachs as the be-all and end-all of treatment, and they are never told about the mechanism of the flatulent distension; and the consequence is that, feeling distended, they dispose of their surplus gas by eructation and are easy for a time. But in so doing they become gas factories; soon more is secreted, and that is passed off, and so on, and the stomach is enticed to produce more each time—the demand, according to the universal rule, creating the supply. If, on the other hand, you tell them that each return of momentary ease is accentuating a habit and really making them worse, and that if they bear with what, after all, is but a slight and passing discomfort, they will soon be better; and then apply such remedies as the case seems to call for, it will take no time to cure the majority of cases. It will not be so easy with a minority. These betoken the intensity of their neurotic degradation, first by the dismal setting of their visage, and then by the minute and exaggerated description of their woes. For these it is hard to say what treatment will suffice.

In addition to these cases, or such as these, there is a far larger class of dyspeptics who come complaining of a troublesome distension after their food, and who, looking upon it as a symptom of indigestion, and due—for this is the common corollary—to something they have eaten, they diet themselves and, meeting with no great measure of success, they apply to us. The old tale of drugs is gone through, and they are dieted and given some pepsine in one form or another. But often enough they are not cured in this way, and, what is more, they will be fortunate if they ever are. Again, I appeal to the experience of anyone here. Who has not felt the same discomfort, more or less, when overworked or harassed in one of the hundred ways that happen to man in this world of everyone for himself? And when you have felt this condition what have you thought of it, and did you take bismuth, or what did you do? Was not this rather the outcome of your deliberations, "Such and such cases have taken it out of me"; or, "I have been busy lately, and had too little time for meals." And to those of us to whom this condition is no uncommon thing, have we not rather thought much in the strain to which I have already given vent, that in these days of hurry-scurry our brains run ahead and take no thought for the stomach, and that in consequence there is almost a necessity for many of us to suffer from a slow digestion; and a slow digestion means that, as regards symptoms, there will be more or less distension after food, sometimes after breakfast, in others after one of the later meals of the day. But taken patiently and not thought about, it all passes off after an hour or two. If we have been wise, we have not done much in the way of medicine; we have, perhaps, taken a little strychnia and phosphoric acid; we have not made much alteration in our diet, which has been plain and wholesome before, but we have taken a little more pains with it, and put food under cover more tenderly, and, perhaps, as a temporary thing, we have added a little pepsine to the meal. No mystery in all this. We have treated ourselves on plain common sense principles. Do we always treat our patients to the same approved methods as we deem fitting for ourselves?

(To be concluded.)

The Lettsomian Lectures

ON THE

SURGICAL TREATMENT OF TRIGEMINAL NEURALGIA.

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LECTURE III.

THE GASSERIAN GANGLION AND ITS REMOVAL.

MR. PRESIDENT AND GENTLEMEN,—In my previous two lectures I have traced the history and gradual development of the surgical treatment of trigeminal neuralgia, clearly indicating the tendency amongst surgeons in this and other countries to substitute more central and radical measures for less effectual peripheral treatment. For however great the relief may be for a time after neurectomy, or combined neurectomy and nerve-stretching, a recurrence of the painful symptoms is unfortunately the rule rather than the exception. In a few months, or perhaps at the end of a year, these patients apply for further treatment, and in many instances are willing to undergo any risk from an operation that holds out the slightest prospect of alleviating their sufferings. They have told me that life under such circumstances is unendurable, and have even threatened self-destruction when the paroxyms have been extremely severe, reason itself being endangered; whilst others have expressed the hope that they might never regain consciousness from the anæsthetic administered at the operation, rather than again experience such exquisite agony. It was a case of this desperate character that first stimulated me to make an attempt to reach and remove the Gasserian ganglion, and after frequent conversations with Dr. Ferrier, and a careful study of the anatomical relations of the ganglion to the base of the skull, I was convinced not only of the possibility but also of the practicability of this proceeding. The results, more or less favourable, following the removal of Meckel's ganglion also acted as a powerful argument in favour of producing a still more satisfactory effect if the Gasserian could be reached and isolated from the brain, even if the whole ganglionic mass could not be excised.

The Gasserian or semilunar ganglion is a small mass of greyish-yellow nerve substance, forming an expansion upon the larger or sensory root of the trigeminal nerve; into it the motor root does not enter, and thus it is analogous to the ganglion upon the posterior roots of the spinal nerves. The trunk of the fifth nerve issues from the pons as a cord flattened horizontally, which passes through an opening in the dura mater to reach the apex of the petrous portion of the temporal bone where the ganglion is lodged. This opening is placed just behind the posterior clinoid process in the anterior attachment of the tentorium, and has the superior and inferior petrosal sinuses respectively above and below it. The space in which the ganglion is located is known as the Cavum Meckelii, and corresponds exactly to the depression at the apex of the petrous bone. It is essentially an extra-dural space, a matter of considerable importance in any operative interference with it. Some French anatomists, however, state that the space is lined

below by a thin reflection of the dura mater, and thus the ganglion really lies encapsuled within the dura; I have, however, experienced no difficulty in any of my cases from this lamella of fibrous tissue. In shape the ganglion is crescentic, or somewhat like a haricot bean flattened out, with the convexity forwards. The two chief surfaces are directed respectively forwards, outwards, and a little upwards, and backwards, inwards, and downwards. The antero-external surface is in somewhat close relation with the dura mater, from which it is not altogether easy to separate it; the postero-internal surface lies on the bone, a thin layer of dura acting as periosteum intervening, and with this it is very loosely connected. The trunk of the fifth nerve enters its postero-superior border at a point corresponding to the hilum, and at the antero-inferior border are given off the three main divisions. The anterior portion is prolonged into the ophthalmic division, which is very closely connected with the dura mater forming the outer wall of the cavernous sinus, and it is a question whether the removal of this portion is possible without laceration of the sinus. Thiersch and Horsley both emphatically contend that the detachment of this portion is impossible, but recent investigations have shown me that on the cadaver at least it can be accomplished, though not without some difficulty. The internal carotid artery, passing upwards in its canal in the petrous bone, lies first below and then internal to the ganglion, previous to gaining its position by the side of the posterior clinoid process in the floor of the cavernous sinus.

The various methods which have been suggested and practised of reaching the ganglion must now be considered. Up to the present this has been accomplished in three different ways, viz.: (1) By Mr. Horsley's intra-cranial operation; (2) by ablation of the superior maxilla and trephining the base of the skull; and (3) by trephining the base of the skull through the pterygoid region, the method which I have adopted in my last four cases. Mr. Horsley is in error when he stated in his paper[1] that I performed the Pancoast-Salzer operation, for, as described in my last lecture, Salzer's method consists in turning down the zygoma, masseter, and temporal *en bloc* by a curved incision, practically perpendicular to the varying directions of the fibres of the temporal muscle. My operation is really an elaboration of Krönlein's[2] modification of Pancoast's original proceeding, except that I make a different skin flap. I have recently received an interesting communication from Professor Andrewes[3] of Chicago, who during the last twelve months has been making investigations on the cadaver as to the best means of reaching the ganglion. He has also sent me details of two cases in which he has followed out my suggestions in his operation, and to which I shall presently refer. His studies have led him to much the same conclusions as to the best and most direct means of effecting this as those at which I have myself arrived. He suggests six different routes; but, inasmuch as two of them are essentially very slight modifications of my own plan, they may, for practical purposes, be reduced to four—the three mentioned above and a fourth, which, however, is only suggested as possible on the cadaver, and is at once condemned by the author himself.

1. With regard to the *intra-cranial operation*, Mr. Horsley has so recently published his views on this subject, and his method of operating, that a detailed description here will be unnecessary; but, briefly, it consists in the exposure of the squamous portion of the temporal bone by turning down a large temporal flap and in the removal of the whole of the exposed portion by means of a trephine and bone forceps. The dura mater is then freely divided along the whole length of this opening, and the temporo-sphenoidal lobe laid bare. "A broad copper retractor with smooth and everted edges is then gently slipped underneath the lobe, and slowly but steadily raised. The lobe is partly moulded, partly lifted upwards, and the floor of the skull is then seen and illuminated by the electric light." The edge of the tentorium is looked for, and the position of the root of the nerve as it emerges from the brain ascertained. The ganglion will not be visible at first, being covered by the dura, but an incision is made at the point where he considers it should be, and by enlarging this the nerve root is stated to be seen with ease, "freely lying in the little canal," to use his own words, and can then be divided and the ganglion removed. The first case Mr. Horsley treated in this way proved fatal in seven hours from shock, and as far as I can make out from the scanty information given in his table of results he had not, when his paper was written, attempted a similar operation again, though in two cases an intra-cranial division of the nerves was undertaken, the exact details of which are not stated, but in neither of these was the ganglion dealt with. An examination of the inside of the base of the skull from which the brain has been recently removed is sufficient to convince one of the difficulties which must be experienced in attacking the ganglion from above; much more so is this the case with the brain *in situ*. Again, when we consider that the ganglion is situated practically outside the dura mater, it seems an unnecessary increase in the severity of the operation to open this investment in two different situations; and, however delicately we may handle the temporo-sphenoidal lobe, it can do it no good to compress and mould it by retractors to a sufficient extent to enable the base of the skull to be clearly seen and the necessary manipulations undertaken. Moreover, Mr. Horsley himself admits that the existence of several small veins passing from the temporo-sphenoidal lobe to the superior petrosal sinus must necessarily be ruptured in this proceeding, and so give rise to troublesome hæmorrhage, and I cannot imagine that the superior petrosal sinus itself can escape if an incision be made in the direction indicated. Bleeding in this locality is difficult to arrest; and even if not absolutely dangerous to the patient from its extent, it may become so by its pressure effects. Again, the extensive removal of cranial bone must be a source of subsequent risk to the patient, and the disfigurement of the face from the large temporal flap is very marked compared with the insignificant cicatrix resulting from my own procedure. These latter points, however, would be of little importance if certain relief could be given to the painful condition without danger to life. From these considerations one cannot resist the conclusion that this method of reaching the ganglion is scarcely justifiable in the light of present experience, and that if the ganglion can be satisfactorily reached and dealt with along some safer route it is far better to avoid the risks certainly associated with an extensive intra-cranial operation.

2. My own efforts hitherto have been entirely directed to reaching the ganglion through the base of the skull, and at present, after an experience of five cases, I see no reason for altering my views. In the first case, one condition on which I was allowed to operate was that I should remove what was thought by the patient to be the seat of the greatest pain—viz., the right superior maxilla; under no other circumstances should I have undertaken such a disfiguring plan of treatment. The operation of ablation of the superior maxilla was performed in the usual way without any difficulty, and, as generally happens, the pterygoid processes broke off close to their base. This gave me plenty of room to expose the foramen ovale, and the trephine was easily applied in a direction upwards and a little backwards. After the removal of the disc of bone containing the foramen as its centre, the ganglion could be easily seen, both by myself and my assistants, by the aid of the electric illuminator, without which manipulations at such a depth would be impossible. At that time I was not provided with the special hooks I have used in my later cases, and so I picked the ganglion away piecemeal with a pair of fine hooked forceps. The wound was of course one communicating with the mouth, and consequently its asepticity could not be maintained. This condition may account in part for the loss of the eye, but with this exception the patient made an excellent recovery. I regret that I did not take proper precautions to render the conjunctival sac aseptic before the operation, or to protect the eye subsequently. It is possible, moreover, that a drop or two of chloroform may have fallen into and irritated it, as the patient was somewhat restless. Be that as it may, subsequent experience would tend to prove that, unless the strictest precautions be taken for the protection of the eye at the time of the operation and for weeks after, the disturbance of the trophic centres may lead to degenerative changes entailing the loss of the organ. But even if the eye should unfortunately be lost, the immunity from pain more than compensates for this.

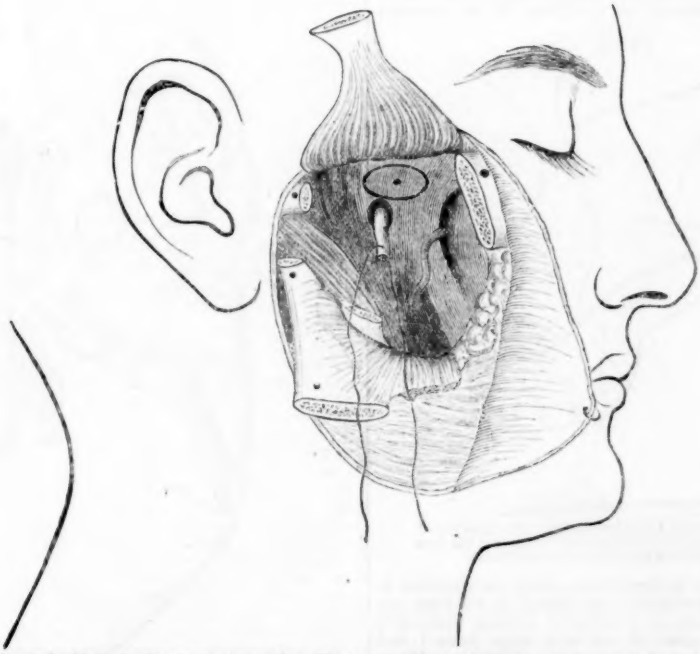
3. I now turn to my present plan of operating through the pterygoid region, which must be described in detail. The patient is carefully prepared in order to be in as favour-

[1] British Medical Journal, Dec. 5th, 1891.
[2] Deut. Zeitschrift f. Chirurg., xx., p. 484.
[3] Papers read in the Section of Surgery and Anatomy at the American Surgical Association, 1891, p. 153.

able a condition as possible. The bowels are moved by a mild purgative given the night before. The face is washed as thoroughly as the patient will permit with soap and carbolic solution (1 in 20) some hours before, and an antiseptic dressing applied. This is an important matter, seeing that (as I have previously remarked) the skin is often very dirty on account of the pain caused by any attempts at washing. Chloroform is perhaps the most convenient anæsthetic to employ, and when the patient is fully under its influence the skin should be again thoroughly washed, the external ear cleansed, and a plug of salicylic or some antiseptic wool inserted into the meatus. The conjunctival sac must also be thoroughly washed out with an efficient but unirritating antiseptic, a 1 in 2000 solution of corrosive sublimate being perhaps the most satisfactory; during this proceeding the lacrymal sac should be squeezed, as often collections of mucus are found therein, and regurgitation of these through the canaliculi will again cause septic contamination of the conjunctiva. In order to ensure closure and protection of the eye, both during the operation and for some days after, two fine horsehair or catgut sutures are introduced through the integument of the upper and lower lids, about 2 mms. from the palpebral margin of either lid, and exactly opposite each other, taking up small folds of the lax skin, which are approximated by tying the sutures. The operation itself may be divided into six stages, as follows:—1. Incision through skin and reflection of flap. 2. Section of zygoma and coronoid processes, and detachment of masseter and temporal muscles. 3. Exposure of the base of the skull, and search for the foramen ovale. 4. Opening the base of the skull. 5. Removal of ganglion. 6. Reposition of displaced structures and closure of wound.

First stage.—The skin incision (Fig. 1) is made by entering the knife over the malar bone about half an inch below the external angular process of the frontal, and carrying it along the zygoma and down in front of the ear over the parotid region to the angle of the jaw, and then forwards along the lower border of the horizontal ramus as far as the facial artery. This done, a flap can now be dissected forwards, consisting of skin and subcutaneous fat only, care being taken not to injure Stenson's duct or any of the branches of the facial nerve which lie in close contiguity to the masseteric fascia. Before this is completed, either a fine catgut thread can be inserted in either side to form a landmark in the subsequent suturing of the wound, or a crescent can be made in the skin. The scar resulting from this incision can be rendered almost imperceptible if great care be taken in stitching the parts together and accurately matching them up. Many other incisions have been devised for similar operations in this neighbourhood, but I do not consider them so satisfactory. Krönlein used an incision which was practically H-shaped, the transverse line being placed over the zygoma. Panconst operated through vertical incisions placed along the anterior and posterior borders of the masseter muscle and joined by a transverse cut along the zygoma. The great objection to these is the anterior vertical incision, which is very disfiguring and of doubtful utility. It is perfectly feasible to dissect up a skin flap in the face without encroaching on the nerves, and I would contend that the curved incision, whilst it gives a maximum of space with a minimum of disfigurement, will in no way interfere with the subsequent mobility of the facial muscles. The skin flap must be carefully protected by a few layers of purified gauze during the operation, and not unnecessarily handled or exposed to pressure or rough manipulation. It is better to avoid retractors in order to hold it out of the way, and its temporary fixation by a catgut suture to the upper part of the chin will be found beneficial. The anæsthetist must prevent any chloroform dropping on the under surface of the flap, and if he be using a towel he must not allow the corner charged with moisture to touch it. Particular stress is laid upon these details, as it is most important not only to maintain asepsis and obtain primary union, but also to leave as little trace of the surgeon's work as possible. After raising the flap any arterial hæmorrhage of importance should be controlled by Spencer Wells' forceps, and probably the transverse facial vessels will need ligature.

FIG. 1.



Sketch from dissected subject, showing stages of operation. The zygoma and masseter are turned downwards and backwards; the coronoid and temporal upwards; the great wing of the sphenoid exposed by detachment of external pterygoid, showing relative position of foramen ovale and trephine track. (For clearness' sake the two latter are purposely placed a little forward.)

Second stage.—The zygoma (Fig. 2) is now cut down upon by an incision along its course, and laid bare by means of suitable raspatories and periosteum detachers. Two holes are drilled at the root of the zygoma, and two also anteriorly through the zygomatic process of the malar line. This is best accomplished by a fine drill driven by a dynamo. The drill used should be of such a size that the perforation in the bone may carry wire of gauge No. 22, and the holes should be about one-third of an inch apart. The bone is then divided between them by a fine saw, and in such a way that the anterior saw-cut is directed obliquely downwards and forwards, the posterior part of the zygoma being divided as near its root as possible. It is obvious that the bone can be drilled much more efficiently whilst the zygomatic arch is intact; it can then be subsequently replaced without difficulty, and maintained in position by means of silver wire. The zygoma thus detached is displaced downwards and backwards together with the masseter; to facilitate this it will be necessary to divide the muscular fibres attached anteriorly to the malar bone. Necrosis of the zygoma has occurred in some instances where it has been detached and turned down by this plan of treatment; but I cannot help thinking that such has been due either to a septic contamination of the wound or to some rough handling of the bone which might have been avoided. Great care must be taken not to interfere with the attachment of the fibres of the masseter

FIG. 2.

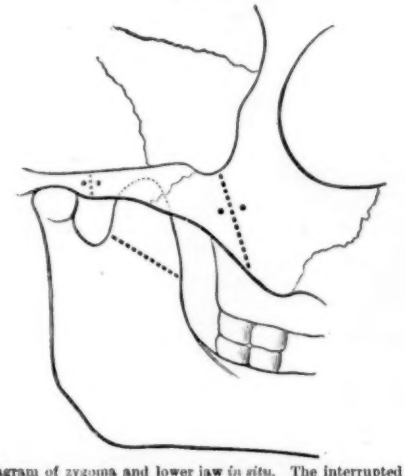


Diagram of zygoma and lower jaw *in situ*. The interrupted lines represent the direction of the saw cuts, and the dots on either side of those in the zygoma the drill holes.

muscle to its under surface, from which its nutrition is derived—and in all probability the wiring of the bone into position after preliminary drilling is another preventive of necrosis, for in none of my own cases have I had the slightest trouble or subsequent difficulty. When the masseter has been drawn downwards and backwards as far as possible, consistent with the integrity of the important adjacent structures, and a little cellular tissue picked away, the coronoid process will be exposed, together with the tendon of the temporal muscle, which, it must be remembered, passes lower down on the inner aspect of the bone than on the outer. In Cases 2, 3, and 4 this process was drilled to provide holes for subsequent wiring, and then sawn off obliquely downwards and forwards. The detached bone was turned up with the temporal muscle, and the deep fibres encroaching upon the ramus of the jaw required careful division. But latterly I have begun to doubt very much the advisability of attempting to gain osseous union of this process; for the temporal muscle attached to it is paralysed by the operation and necessarily atrophies, with the result that very considerable impairment of the mobility of the jaw ensues. In my last case, therefore, I simply divided the coronoid without attempting to drill it, and drew it and the muscle upwards out of the way, subsequently excising it and a portion of the temporal tendon.

Third stage: Search for the foramen ovale.—A certain amount of loose cellular tissue and fat will now present, under which will be found the external pterygoid muscle, running transversely backwards, to be inserted into the condyle of the jaw; and perhaps below it a small portion of the internal pterygoid may be seen. Running superficially across the former muscle, between it and the jaw, the internal maxillary artery is usually found, which passes into the spheno-maxillary fossa by dipping between the heads of the muscle. The artery, if it has not been tied at a previous operation, should now be sought for, and divided between a double ligature; by this means hæmorrhage, which might be troublesome during the later steps of the operation, will be avoided. The inferior dental and gustatory nerves under normal circumstances pass downwards from under the lower border of the external pterygoid muscle; but if they have been previously removed, their assistance in guiding the surgeon to the foramen ovale is not available. The external pterygoid muscle is next detached from the great wing of the sphenoid

FIG. 3.

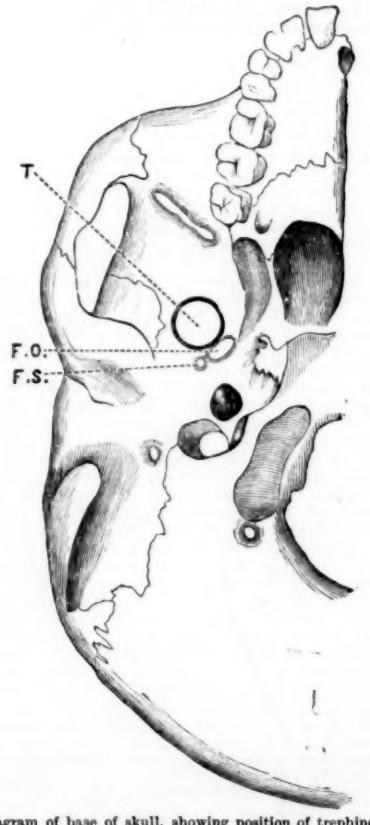


Diagram of base of skull, showing position of trephine track. T, Trephine track. F O, Foramen ovale. F S, Foramen spinosum.

and from the outer surface of the external pterygoid plate, by scraping it off the bone with suitable raspatories; it is of course pushing it downwards. The knife should be used as sparingly as possible, and the strands of muscular tissue are best picked and cut away with dissecting forceps and a fine pair of blunt-pointed scissors. By this means the under surface of the great wing of the sphenoid is exposed, and the outer pterygoid plate. The foramen ovale is now to be brought into view, a matter often of some difficulty, and the occasional reference to a dry skull held by an assistant will be a considerable help in indicating its position in relation to the neighbouring landmarks. (Fig. 3) It is usually on a level with the eminentia articularis, but occasionally lies a little behind it. In fact, the portion of bone which one first reaches in this deep part of the operation is well in front of the foramen, and one is apt to get too far forwards,

so that the pterygo-maxillary fissure is mistaken for it. In the third of my cases this actually occurred, and at first I trephined the sides of the fissure, not discovering my mistake until I found orbital fat protruding from the opening. The relation to the root of the pterygoid processes is another guide; the foramen lies usually a little behind and external to the base of the outer plate, but sometimes directly behind it. The position, however, is not constant, and Mr. Carless has found the greatest variety in the skulls which he has examined for me. "The base of the external pterygoid plate," he states, "is by no means a fixed guide, in that in many old skulls there is a formation of bone (like a tongue) projecting backwards towards the spine of the sphenoid, usually external to the foramen ovale, and deeply channelled or grooved for the middle meningeal artery." M. Testût[4] also mentions this fact, stating that it is due to an ossification of the pterygo-spinous ligament of Civinini. The sphenoidal spine lies immediately behind the foramen ovale and about a centimetre from it, the foramen spinosum intervening and placed about 2 mms. behind the oval opening; the spine cannot, however, always be felt on the living subject on account of the depth of the wound and the limited space in which one is working. Under these circumstances it is important to define clearly with the finger the outer pterygoid plate, and help may be obtained from the facts ascertained by the measurement of a number of skulls by my colleague, that in an adult male skull the average distance from the anterior border of the outer pterygoid plate—i.e., from the posterior lip of the pterygo-maxillary fissure—to the centre of the foramen ovale is about 18 mms., whilst in the female adult skull it is about 16·5 mms.; in both sexes the average measurements are a little greater on the right side, but in skulls that are abnormally large or small these vary to a corresponding degree. Should the above-mentioned pterygo spinous ridge of bone exist, it may be necessary to clip it carefully away in order to define the position of the foramen.

Fourth stage: Opening of the base of the skull.—Having thus exposed the foramen ovale and traced to it either the trunk of the undivided lingual and dental nerves, or the stump left from former operations, the base of the skull is now to be opened by means of the trephine. My intention in Cases 2, 3, and 4 was to remove a disc of bone having the foramen ovale for its centre, and for this purpose I employed a trephine with a handle set on a stem long enough to clear the cheek, and with a reversible centre-pin, one end of which was pointed as usual, the other blunt. The size of the trephine was such that it should remove a half-inch disc of bone; the crown was serrated obliquely on the outer side for a distance of a quarter of an inch in order that the trephine might clear itself of débris and not get jammed in the bone. The smooth-ended centre pin was projected from within the crown as far as possible, and introduced into the foramen ovale, so that the blunt point might protect the dura mater or other intra-cranial structures by pushing them before it. To do so the trephine was, roughly speaking, held in such a position that its axis was parallel to the external pterygoid plate. The handle of the trephine was then depressed and kept as far back as possible; but from the pressure of the soft parts it was always applied at an angle and not perpendicular to the surface, a proceeding not altogether undesirable, inasmuch as thereby the integrity of the carotid canal could be more readily maintained. The close contiguity of this structure had to be carefully kept in view during this stage of the operation; and, indeed, there is only the inner border of the great wing of the sphenoid, measuring from 2 to 4 mms. in thickness, intervening between it and the foramen ovale. By holding the trephine at this angle the outer segment of the bony circle was cut through first, and then the bone could be broken off on the inner side along the sutural line between the apex of the petrous bone and the great wing of the sphenoid, and thus the carotid canal remained uninjured. But even if it should be encroached upon, it by no means follows that the artery lying within will be damaged, as there is always a certain amount of space to allow of its expansion and other movements under the blood pressure. The portion of bone being now set free by an elevator, will fit like a collar over the stump of the divided nerve, and can be slipped over it. In one or two of my cases I noticed a definite constriction of the nerve at this point. In Case 4 I made an important modification by trephining in addition the great wing of the sphenoid anterior and a little external to the foramen. The trephine openings were then united by removing the bridge of bone between by a careful use of chisel and mallet. During this process the dura mater, which had been previously loosened around the openings, was protected by a spatula, and held up out of the way, for when unsupported the dura bulged through the opening. As will be seen by reference to the account of my cases which I append, this patient did well; but during the first forty-eight hours after the operation she had a certain amount of epistaxis, and also vomited some grumous material like coffee grounds, which was evidently altered blood. The source of this was a matter of considerable anxiety to me; it evidently did not come from either the sphenoidal sinus or the antrum, as these were in no way interfered with; but on careful examination of the base of the skull the relationship of the Eustachian tube, which had been previously overlooked by me, seemed clearly to indicate whence the bleeding was derived. This structure lies in immediate contiguity to the ridge of bone which forms the inner boundaries of the foramina ovale and spinosum. A groove will be found in this position in most skulls extending backwards to the point of attachment of the tube to the petrous portion of the temporal bone and forwards to the base of the pterygoid process; and this

FIG. 4.

Diagrammatic section of base of skull and lower jaw (after Andrewes), showing relation of trephine to foramen ovale and Gasserian ganglion.

region in the living subject is occupied by the cartilaginous portion of the tube. It is highly probable that in removing a disc of bone half an inch in diameter, with the foramen ovale as its centre, this tube will be encroached upon, laying the wound open to the risk of septic contamination from the pharynx. This consideration was one of several which induced me to alter my plan of operation in the last case I dealt with, and in consequence I applied the trephine to the great wing of the sphenoid a little anterior and external to the foramen, and in such a way that the circumference of the disc just impinged on its outer wall. (Figs. 3 and 4.) The opening thus made can be subsequently enlarged, if necessary, in any direction desirable. It must not be forgotten that the thickness of the skull is very unequal, being thinner on the outer margin of the trephine track than on the inner; and inasmuch as the instrument is necessarily applied at an angle, the outer half will be cut through before the inner. This fact renders damage to the dura mater possible, unless careful precautions be taken.

Fifth stage: Removal of the ganglion.—Having repressed the prominent dura with a spatula, the third division, which during all these preliminary proceedings has been carefully guarded, and round which a ligature should now

[4] Traité d'Anatomie Humaine, 1889, vol. i., p. 113.

be passed, is to be traced up to the ganglion, which should be loosened from its resting place upon the apex of the petrous portion of the temporal bone. No great difficulty need be experienced as regards the posterior half, but inasmuch as the anterior and upper portion is closely incorporated with the dural sheath, it is perhaps better to sever the connexion between the ganglion and the brain at its exit from the dura mater, and then to draw it forwards with a delicate pair of forceps. For this work a pair of fine hooks (Fig. 5) that have been made for me by Mr. Hawksley are most useful; one of them is an ordinary blunt-pointed hook, to pass round the nerves and free them from their connexions; the other has a sharp edge upon its concave aspect, to be used for cutting them through. It is quite possible that in dividing the root of the nerve just outside the dura a prolongation of the subdural space may be opened, and a small quantity of cerebro-spinal fluid escape through it; this, however, will be of slight extent, and is of no moment if the wound be kept aseptic. The second division of the nerve must now be dealt with, and this may be facilitated by enlarging the opening in the base of the skull in the direction of the pterygoid processes, and holding up the dural wall out of the way; it is to be divided just in front of the ganglion by the sharp hook. Having thus severed all its connexions except the ophthalmic division, the ganglionic tissue, which is exceedingly soft, may be pulled away piecemeal by forceps or by a small curette as recommended by Professor Andrewes. In this way the danger of wounding the cavernous sinus is reduced to a minimum.

FIG. 5.

Hooks for dealing with the ganglion (actual size). A, Enlarged sketch of hook, to show concave cutting edge.

Sixth stage: Reposition of displaced structures and closure of wound.—After the steps detailed above have been satisfactorily accomplished, the toilette of the wound must be attended to. The bleeding having been stanched, the parts should be thoroughly washed with a 1 in 40 solution of carbolic acid. The coronoid process may now be either sutured or removed; in my last case I removed it. Silver wire should be passed through the holes previously drilled in the zygoma, and it can thus be accurately adjusted. By this means the contour of the face will not be interfered with, the chances of necrosis or collapse of the zygoma prevented, and firm bony union assured. The integuments may now be brought together with a continuous fine catgut suture, care being taken to adapt the parts accurately to each other. No drainage-tube is needed, although I used it as a precautionary measure in my first two cases. If the wound has been occasionally irrigated during the operation, and all other antiseptic measures observed, primary union may certainly be expected, and it is most important from every point of view to obtain it. I am glad to say that no suppuration has occurred in any of my cases. To prevent accumulation of blood in the wound, gentle but continuous pressure by means of a purified sponge introduced between the second and third layers of the cyanide gauze will be found very efficacious. In addition to the face dressing, both eyes should be carefully covered with eye pads of salicylic wool, and lightly bandaged. A certain amount of shock necessarily follows such a protracted operation, and a subsequent elevation of temperature must be expected at the end of about forty-eight hours. Beyond this no symptoms of importance have been exhibited. The dressing has usually required changing once or twice in the first four days, at the expiration of which time it may be replaced by gauze fixed down with collodion. The stitches can be removed at the end of a week if they have not already been absorbed. The eye should be kept closed for at least four days, when the stitch in the lids may be removed; but it is safer to keep both eyes bandaged for a week, and the eye on the side operated on for three or four weeks.

I append a brief *résumé* of my cases:—

CASE 1.—Mrs. F. M——, aged sixty, sent to me by Dr. Padman of Bloomsbury, first came under my care in 1888. She had been suffering for five years from severe neuralgia, which had specially affected the inferior dental nerve of the right side. Counter-irritation and constitutional treatment having failed, the dental nerve was stretched at the entrance to its canal through the mouth on August 19th, 1888, and at the same time was divided at its exit from the mental foramen. This was followed by relief until March, 1889, when the pain returned with great severity, for which the lower jaw was trephined and half an inch of the nerve excised. Partial relief followed for a year; but in March, 1890, the lingual and dental nerves were cut down upon by deepening the sigmoid notch, and divided close to the base of the skull. The pain now recurred in the second division with greater intensity than before, any touch upon the jaw of that side producing a shock of agony terrible to witness. On April 2nd, 1890, I performed ablation of the superior maxilla, together with trephining around the foramen ovale, and removal of the ganglion. The patient made an excellent recovery with the exception of the ocular trouble already alluded to. The latest report, dated Jan. 28th, 1892, states that she is still quite free from pain, and her general health very good.

CASE 2.—Mrs. S. C——, aged sixty-three. The neuralgia had commenced ten years before she came under observation in connexion with the teeth of the right lower jaw, and in spite of all treatment it spread to other branches and increased in severity. In 1884 all the teeth on the right side both of the upper and lower jaws were extracted, but without any relief. Drugs and local applications had no effect. When first seen by Dr. Ferrier and myself the case was typical, a paroxysm being elicited by almost any movement of the jaw or stimulus from without; the pain chiefly affected the lingual and dental nerves and the back of the orbit, and shot down into the palate. In consequence of the evident implication of the second as well as the third division of the trigeminal, Dr. Ferrier recommended that the Gasserian ganglion should be dealt with at once, without having recourse to any minor measures. This was done on Jan. 29th, 1891. The foramen ovale having been exposed through the pterygoid region was trephined, and the opening extended with a larger trephine. The ganglion was then removed piecemeal. The patient made an uninterrupted recovery. The eye was anæsthetic when exposed four days after the operation, and the conjunctival reflex was diminished for some time, but no trophic disturbance manifested itself. Slight difficulty in mastication was subsequently experienced, but this soon passed off. There has been no recurrence of the neuralgic pain, and the patient was seen by me only a few days ago.

CASE 3.—Mrs. E. K——, aged sixty-three. The neuralgia in this patient dated back for about five years, starting in the inferior dental nerve as the result of carious teeth, which were removed, but without benefit. About February, 1890, I divided the inferior dental and gustatory nerves close to the foramen ovale by deepening the sigmoid notch. This was followed by relief for about a year, when she was readmitted to hospital with pain in the second and third divisions, but especially referable to the superior maxillary. The operation was performed on Oct. 29th, 1891, by the usual incision and with the usual precautions. The great wing of the sphenoid and external pterygoid plate having been cleared, what was at first considered to be the foramen ovale was exposed and the trephine applied; the appearance of some orbital fat, however, through the trephine hole indicated that the pterygo-maxillary fissure had been mistaken for it. The raspatory was again employed further back, and the foramen ovale clearly demonstrated. Owing to the previous operation there was less hæmorrhage than usual, but the tissues were much matted together, and so interfered with the application of the trephine. The base of the skull was opened and as much of the ganglion as could be seen removed. The wound was treated as usual, both coronoid and zygoma being wired, and healed without trouble. For a time the right eye was painful and the conjunctiva congested with some œdema of the lids, but there was no disturbance of the corneal epithelium. The greater portion of the right side of the face was

anæsthetic for the first five days after the operation, but this gradually diminished in extent; so that when she left the hospital on Nov. 30th there was a partial return of sensation over the first and third divisions. The cheek, lower eyelid, and upper lip had, however, completely lost their sensibility to touch and pain, and the right side of the tongue was still dull. The patient returned a few days ago complaining of inability to open the mouth, which I remedied by forcible depression of the lower jaw under an anæsthetic. The only other complaint was a slight occasional pain and intolerance of light in the right eye.

CASE 4.—Mrs. D——, aged thirty-seven. In this patient the disease seems to have originated about twelve years ago in a bad tooth in the right side of the lower jaw. In 1887 I trephined the lower jaw and removed half an inch of the inferior dental nerve, with temporary relief, but the pain recurred under the right eye, in the tongue, and again along the jaw. In July, 1890, portions of the inferior dental and gustatory nerves were removed by deepening the sigmoid notch, but the relief given by this proceeding was of short duration, and the pain recurred with more than its old severity, extending down into the neck and up to the temple. On Nov. 5th, 1891, I operated for the removal of the Gasserian ganglion. The operation was performed in the way detailed above and the skull trephined in two places, one posteriorly having the foramen ovale for its centre, and the other a little anterior and external to it, the intervening bridge of bone being removed by chisel and mallet. In consequence of the thickened state of the third division, it was difficult to draw the disc of bone over the stump, but when this had been accomplished the foramen was found to be very small. By detaching the dura mater the ganglion was seen and even felt by the finger, and by cutting through the different divisions was removed; the opening in the dura for the passage of the root of the nerve was clearly defined, and through this a small quantity of cerebro-spinal fluid trickled. During the removal of the ganglion the dura, which had a tendency to bulge, was lifted by a bent spatula. The after history of this case has been satisfactory. I have alluded already to the fact that some epistaxis and vomiting of altered blood occurred, probably from damage to the Eustachian tube. The wound healed throughout by first intention. One week after the operation the sensation of the right side of the face and tongue was carefully tested, and found to be much decreased, although not totally absent. Between two and three weeks after the operation the right eye became somewhat congested and irritable from the development of a crop of small subepithelial vesicles on the lower fifth of the cornea, which burst in a few days and left a superficial ulcer, which, however, readily healed under suitable treatment, and the congestion gradually disappeared. The eye pad was in this case retained for six weeks. The patient was examined on Jan. 27th, 1892, and there has been no recurrence of the pain.

CASE 5.—Mrs. B——, aged thirty-seven, sent up from Derby Infirmary by Dr. Taylor, had suffered from epileptiform tic of the second and third divisions for seven years. She had teeth extracted from upper and lower jaws on the affected side, but this rather increased the trouble than otherwise, and the usual medical treatment had been tried without benefit. Paroxysms were excited by masticatory movements, even after removal of the teeth; they lasted about two minutes, and recurred about every half hour. They could also be elicited by pressure over the points of exit of the second and third divisions. After consultation with Dr. Ferrier, and in consequence of the evident implication of both the supra- and infra-maxillary divisions, it was decided to cut down upon the Gasserian ganglion.—Jan. 16th, 1892: The usual incision was made, and the zygoma, which in this case was very slender, was exposed, drilled, sawn through and turned down. The anterior saw cut was made close to the malar bone, which was drilled on the slant to clear the root. The coronoid process was cut through, and the temporal muscle turned up and held out of the way. Troublesome bleeding from the pterygoid plexus of veins ensued, interfering for some time with the identification of the trunk of the internal maxillary artery, which was, however, finally secured. The external pterygoid muscle was scraped away from the skull, exposing the great wing of the sphenoid, together with the anterior margin of the foramen ovale. The trunk of the nerve emerging from this was now isolated, ligatured, and divided. The trephine was applied to the great wing of the sphenoid anterior and external to the foramen ovale, the circumference of the trephine track just touching it. Owing to the thinness of the bone in this position the edge of the trephine wounded the dura mater, so that the temporo-sphenoidal lobe could be subsequently seen. The trunk of the third division was lifted from the foramen into the trephine hole and traced up to the ganglion, which was then loosened from its connexions, and probably the posterior half only removed. Before closing the wound the coronoid process and about an inch of the temporal tendon were excised. The patient was somewhat collapsed after the operation, and complained of pains in the top of the head and in the limbs. The temperature rose to 101·4° on the second day, but has since been normal. There has been none of the old pain since the operation. I shall anxiously watch the future progress of this case, for I think it highly probable that the anterior half of the ganglion was left completely undisturbed, and the cerebral root but partially divided, an occurrence attributable to the limited opening I made in the skull and to the troublesome hæmorrhage protracting the operation. The anæsthetic area in this case is not so complete as in the others, and seems mainly confined to the third division. The sense of taste is completely lost on the right side of the tongue; this was carefully tested by Dr. Ferrier a few days ago with salt, sugar, and quinine.

A sixth case was operated upon in Chicago on Nov. 7th, 1891, by Professor Andrewes in a similar manner. The patient was a woman aged fifty, who had suffered for five years from "frightful pain along the inferior maxillary division without being able to obtain any relief, the act of swallowing being especially associated with the paroxysms." He trephined the base of the skull by the side of the foramen ovale and broke up the ganglion thoroughly with a curette. The patient, who was very weak, felt the shock considerably, but rallied after a few hours, and was free from neuralgic pains. There was complete benumbing of all the parts supplied by the ganglion, and swallowing was no longer painful. The motor oculi nerve was paralysed, showing that it had been injured, probably by the curette. In ten days she was able to return to her home fifty miles distant, although the wound was not quite healed, and it suppurated slightly afterwards. I had another communication from Professor Andrewes recently, dated Jan. 15th, 1892, stating that this patient had remained free from pain; that the paralysis of the motor oculi proved only temporary, but there was a slight tendency to pericorneal ulceration of the right eye. He also sends me particulars of another case in a woman sixty-two years of age, the disease being on the right side, and involving the second and third divisions. He had previously removed the inferior dental branch close to the foramen ovale. The operation was performed in the middle of last December in the same way, by trephining just external to the foramen ovale, and removing the ganglion with a sharp curette. There was troublesome hæmorrhage during the operation. Up to the time of his writing the patient was perfectly free from pain.

Results of operation.—In considering the results of partial or complete removal of the Gasserian ganglion, the first question which has to be answered is naturally "What effect has this proceeding upon the pain?" Up to the present time we are able to give a satisfactory reply; all the five patients whom I have treated in this way have remained free from the typical and terrible paroxysmal attacks from which they had previously suffered. It is true that my first case was done only twenty-two months ago, and the last only sixteen days; consequently, it is too early to speak with confidence as to the permanent character of the relief; but the results hitherto obtained are sufficiently encouraging to lead me to continue in the same line of action. Absolute immunity from any kind of pain can hardly be expected after such a considerable disturbance of the structures at the base of the skull, and for some time there may persist a sore and stiff sensation about the region operated on as well as pains in the head; but these are not considered of any moment by patients who have previously suffered such intense agony. The interference with the movements of the lower jaw is undoubtedly inconvenient, and renders the process of mastication a little difficult; but I hope that this may be avoided in the future by the removal of the coronoid process. As to the effect upon the distribution of the sensory fibres of the fifth nerve, it is interesting both from the clinical and physiological aspects to observe the rapid diminution of the anæsthetic area, and it would appear that the

distribution of sensation is taken up by the neighbouring branches much in the same way as arterial anastomosis takes place in the vascular system. This re-establishment of sensation is a fact which cannot be disregarded prognostically, although it is not necessarily the precursor of a relapse. The appearance of the side of the face operated on is characteristic of trophic disturbance; the skin has a shiny, somewhat injected look, whilst the hollows in the temporal, pterygoid, and maxillary regions on that side clearly demonstrate the existence of muscular atrophy and cicatricial deposit. The effect upon the nutrition of the eyeball is decidedly serious. In the first case, as is well known, the organ was lost, a result of suppurative panophthalmitis, and in two of the other cases the nutritive state was for the time considerably depressed. It is probable that the trophic centres for its nutrition are contained in the upper and anterior segment of the ganglion, and if this be so, the chances of damaging the eye may be lessened by leaving this portion intact, even though the trunk of the nerve be divided behind the ganglion. On the other hand, the interference with one part of the ganglion may induce degenerative changes in the remainder, which will effectually prevent a recurrence of the malady, and yet will not be sufficient to cause permanent damage to the eye.

Such are the results, Mr. President and gentlemen, both of my own observations and experience, together with that of others, in this department of surgery, and from them I venture to draw two very definite conclusions: (1) That in severe cases of epileptiform neuralgia both medical and surgical treatment have hitherto been unavailing to give permanent relief; and (2) that exposure and partial extirpation of the Gasserian ganglion through the base of the skull, though admittedly difficult, need not endanger life, and at present holds out the best prospect of dealing with these intractable forms of trigeminal tic. The test of time and further experience can alone decide what value will be finally attached to this measure; but at any rate the outlook is hopeful, and let us trust the future will not belie our present expectations.

(During the lecture, which was illustrated by diagrams and microscopical specimens, Mr. Rose demonstrated the different stages of the operation on the cadaver.)

THE BEARING OF RECENT BIOLOGICAL RESEARCHES ON THE PRACTICE OF MEDICINE AND SURGERY.

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(*Concluded from page 245.*)

THIS question of internal metabolism has a far more important bearing on treatment in disease than would at first sight appear. It is a well-recognised fact that all cells, when stimulated in excess of their powers of taking up nutriment, utilise for food material the protoplasm of which they themselves are made up: and altered metabolic processes, ending in grave degenerative changes, go on. We find that a cutting off of the food supply has a similar effect. Taking, as an example, the muscle fibre of the heart or the protoplasm of the liver cells, we find that in the course of an attack of fever, under the stimulation of a high temperature—under the influence of which metabolic activity is always increased, and under the action of the toxic substances, associated with the production of the disease, circulating in the blood—the protoplasm passes through a stage of cloudy swelling, which is evidence of the increased activity of the protoplasm, and then, if the process is continued, merges into well-marked fatty degeneration. In certain very acute diseases such degeneration is not confined to the excretory glands or to the heart muscle, but has frequently been observed in both nerves and muscles, especially in connexion with diphtheria and typhoid fever. From what we know of the clinical symptoms presented in influenza there can be little doubt that here similar marked metabolic changes may be initiated during the course of an acute toxic condition, the result of the vital activity of the specific organism associated with this disease.

Wherever this condition occurs two things should be carefully borne in mind: (1) that recovery may take place if the fatty degeneration is not so far advanced that the active protoplasm of the cells is absorbed; (2) that for recovery to take place it is essential that the cells should be placed under the most favourable conditions as regards nutrition; that not only should they not be over-stimulated, but that they should have absolute rest, as far as possible, from their ordinary work. How often are these conditions kept in view when patients are recovering from acute specific fevers? Some physicians, undoubtedly, arguing very rightly from the condition of the pulse in these diseases that the patient is in a greatly enfeebled condition, order rest for lengthened periods, forbid exertion of any kind, especially such exertion as is calculated to throw even a moderate strain on the heart. They know how frequently dilatation follows any exertion taken before the tone of the heart muscle has recovered; but how many bear the same points in mind as regards the liver, the kidney, the voluntary muscles, and even the brain cells and nerve fibres during convalescence from similar diseases? How often, except in such conditions as scarlet fever, do we consider the enfeebled condition of the kidneys, and take into our calculations the diminished powers of the liver to perform its ordinary functions; whilst, passing still further back, what consideration do we give to the lymphatic glands and the tissues of which they are composed, tissues which during the acute stages of the specific diseases have had so much extra work thrown on them, and which must require rest and careful nutrition in order that they may be brought back to their original healthy condition? Whoever considers that it is necessary to think of the leucocyte and its near relation the connective-tissue cell in this connexion? It is only when we come to look on them as extremely active agents in nutrition, metabolism, and excretion that we bring ourselves to appreciate their importance, and to recognise the necessity of getting to know something of their life history and of their relation to disease.

The leucocyte has been looked upon by different observers as a separator and carrier of fat, of glycogen, and of certain excretory products; as a producer of peptone, as a scavenger and as a policeman; as a prominent factor in the process of keeping the fluid constituents of the body in a state of equilibrium; as an important element in the causation of coagulation; in fact, according to the special line of work on which men have been engaged, so have they assigned functions to the leucocyte. The bulk of evidence that they have been able to bring forth in support of their theses, moreover, compels us to accept it as possible that they are all correct in so far as the leucocyte seems to play no secondary part, at all events, in many of the above-mentioned processes. We are, in fact, brought back to the biological standpoint that, for the explanations of many of the most important questions in general physiology, we must refer to the processes that are going on in the elementary cells of the body, where we may find bound up in one comparatively slightly differentiated mass of protoplasm all the functions that are more highly developed, each in its own form of cell.

Many writers, especially those who speak of themselves as being intensely practical, are in the habit of sneering at laboratory work and of speaking lightly of the acquisition of new methods and of the discovery of isolated facts in various regions of biological research. But when we come to go over the history of medicine and to compare our knowledge gained empirically with that gained by experiment, we cannot but be struck with the difference in character of the knowledge gained by the two methods: in the one case the fact remains, however it may from time to time be interpreted; whilst in the other case everything connected with it is constantly changing. Of the second method little need here be said; but of the first method we may take for our example the condition of the blood and its relation to certain diseases, and of its importance in certain modes of surgical treatment. In the study of coagulation, facts have been gradually accumulated which, taken together, have from time to time enabled physiologists to throw light on the processes that take place during the coagulation of the blood. We have had described, for instance, the effect of the presence of fibrin ferment and tissue fibrinogen in the blood, and the influence which the presence of soluble lime-salts exerts. Each of these facts in itself had a comparatively transitory interest for the practitioner, because not one of them promised any benefit to his patient.

Dr. A. E. Wright,[1] however, following up the researches of Schmidt, Wooldridge, Hammarsten, Ringer, Green, Arthus, and Pagès, each of whom has contributed some isolated fact to our knowledge, has been able to apply in a most interesting fashion the knowledge so obtained, and to render this work useful from the point of view of treatment. He employs a fibrin ferment solution, to which is added 1 per cent. of calcium chloride, as a styptic, which brings about coagulation of the blood. It has the very great advantage that, whilst clotting the blood itself, it has no deleterious action on other tissues, as he says "such a styptic exerts an elective influence on the blood, and is perfectly inert when brought in contact with other tissues, and is therefore perfectly painless in its action. Further, the coagulative influence which it exerts upon the blood probably takes place along the natural lines upon which normal blood coagulation occurs." It undoubtedly brings about extravascular coagulation. At first sight it might appear to be an equally easy matter to induce coagulation within the vessels, and to utilise the method in practical medicine; but in such cases dangerously large quantities had to be employed. It was even thought that by injection of tissue fibrinogen into the vessels coagulation might be induced, and that a means of checking internal hæmorrhage had thus been obtained. Experiment, however, proved that in some cases the coagulability was certainly increased, and, where smaller quantities were employed, the coagulability was considerably diminished both before and after the blood was shed; and it was found that in these cases the injected materials were transformed in the circulation into substances (probably albumoses) which rendered the blood less coagulable than in the normal condition. When, however, a solution of calcium chloride—a substance which, as we have already seen, is essential for the coagulation of the blood—is injected clotting takes place wherever the vessels are injured, but apparently at no other points. It is quite unaltered by contact with the blood itself, and thus is ready to help on the process when the other conditions necessary for coagulation are present. The importance of this in cases of hæmophilia, of post-partum hæmorrhage, and of internal hæmorrhage of various kinds, in aneurysms where the walls are somewhat altered, and where the conditions for clotting are certainly favourable, can scarcely be over-estimated, and the internal administration of calcium chloride as a styptic may prove to be of enormous advantage. This has been worked out from the experimental point of view, and the fibrin ferment and the calcium chloride styptic have proved so useful in stopping hæmorrhage when applied externally that we may confidently anticipate this styptic will come into very general use in the treatment of refractory hæmorrhages of various kinds.

Many other experiments on the blood have led to the acquisition of knowledge the importance of which we are not yet in a position accurately to estimate. A new kind of corpuscle has been discovered, an increase in the number of leucocytes in the blood has been demonstrated after the injection of tissue fibrinogen and of other proteid substances, and conditions very similar to those met with in leucocythæmia have been produced by the injection of certain of the proteid products met with in the course of various diseases, and many theories as to the relation of this increased number of leucocytes in the circulation to the protection of the individual against disease, especially those of a specific character, have been formulated. The relation between the increased number of leucocytes to an increase of peptone[2] and of uric acid[3] in the urine has been traced in cases of leucocythæmia, and has similarly been followed out in the course of leucocythæmias produced experimentally, and we may anticipate that before long other information may be obtained by a further study of these facts.

In no region of experimental research has there been a more immediate outcome as regards treatment—especially from the surgical point of view—than in that of nervous pathology and physiology, and the whole band of enthusiastic students of a most interesting branch of physiology may congratulate themselves that they, at any rate, have not carried on their work in vain. The localisation of function in certain areas of the brain—though still a matter for discussion and experimentation—has opened up a new region of surgery, a region in which our best surgeons have excelled themselves, and one that has afforded brilliant opportunities of obtaining most successful results to some of our younger surgeons, trained in the most exact methods and prepared by a long course of accurate experimentation, in which the importance of carrying out exact details and new methods had been insisted upon in an almost exaggerated degree. The result is that in no domain of surgery has such satisfactory results, as far as the welfare of the patients is concerned, been obtained. We cannot maintain yet that the localisation of the paths of sensation and of motor impulse in the cord and in the brain have been definitely worked out, but we can see before us a prospect which is gradually opening up; each fresh point gained opens up a wider view, and one that promises some important practical results, for no scientific worker, however fully he may be imbued with a love of truth for its own sake, can be content with the outcome of laboratory work were he not assured that the ultimate practical benefits to the science and practice of medicine, the alleviation of suffering, and the prevention of disease would accrue from the knowledge that he may be able to acquire.

The triumphs of cerebral surgery by contrast throw into comparative insignificance the work that has been done on the spinal cord; but for all that great strides are being made in the advancement of our knowledge of the physiology of the cord, and we may rest assured that ere long this knowledge will receive further practical application, as glimmerings of light as to the paths of conduction are already being obtained. Moreover, the nature of many of the pathological processes in the cord is now much more fully understood than it has been at any previous period in the history of medicine; the results of concussion, the protean nature of which for so long puzzled railway surgeons and others, have received their explanation on the assumption, now proved to be correct, that they are due to inflammatory changes set up, running their course comparatively slowly, but leading, nevertheless, to interference with the functions and with the conduction of sensory or motor impulses along the nerve tracts. Such conditions as locomotor ataxia and peripheral paralysis are now explained as being the result of neuritis and myelitis. It has of course long been argued that some of these forms of disease are the result of such a condition as syphilis, even before the changes met with in syphilis were supposed to be due to the action of a specific micro-organism and its products; and now that the degenerative changes in nerves, met with in such diseases as diphtheria and typhoid fever, have been associated with the presence of an organism and its poison, we can see what a fertile field of research is opened up, and what ultimate practical results may be obtained from a study of earlier experiments and observations. Any one of the series of observations above mentioned could alone give us little help in our study of these disease processes; but when they are collated and arranged, and deductions are made as a result of their study, we are led from point to point, and ultimately we may hope to gain that accurate knowledge which will enable us to claim for this branch of medicine and surgery that it is not merely an empirical handicraft, but both an art and a science in the truest sense of the word.

One fact that has been brought home to us very forcibly during the last few years is that we have been arguing too directly from the general to the special, when our knowledge of the general has been far too limited; we have been discussing the modifications and special transformation of protoplasm before we have thoroughly understood what protoplasm is; we have assigned special functions to special kinds of cells, and have assumed that on the development of these special activities most of the other functions have been obliterated. We are now gradually beginning to find out that we have been apt to confine our studies too closely to the extremes of undifferentiated protoplasm and of cells in a high stage of differentiation, and that we have ignored all those intermediate stages by the study of which alone we are able to gain a wider and more accurate knowledge of cell activity and cell transformation. Moreover, we are now coming to see that animal and vegetable protoplasm are not so divergent as regards their character as many would have us believe, and that now, with the modern methods of bacteriological research at our disposal, we may study many of the central truths of physiology in the minute specks of vegetable protoplasm known as bacteria.

[1] Brit. Med. Journ., Dec. 19th, 1891.
[2] V. Jaksch and Wright.
[3] Horbaczewski: Sitzber. Wien. Akad., 1891

In them we may find combined not only the characters common to all protoplasm, but we may also observe in them some of the highest forms of specialisation of function and energy production. In them we have organisms existing under such conditions and proliferating at such an enormous rate that we are able to modify the surroundings through an enormous series of generations, and to watch the modifications brought about under different modified conditions.

Now that bacteria have been accepted as being the cause of specific infective diseases, we are able to explain certain of the peculiarities of the outbreaks of epidemic diseases, and, having traced these to their source, our prospects of being able to modify or to cut them short are certainly much brighter than they have ever yet been. Even the mystery-enshrouded influenza must gradually yield some of its secrets, and it is already reported that isolation and disinfection have done much in certain crowded institutions, such as asylums, to cut short the ravages of the epidemic. If we are to accept what those who have studied the organism found in the tissues and cavities of the body in this disease have told us, we have an organism which, though under certain conditions extremely virulent and readily transmitted directly from patient to patient, soon loses this virulence when grown outside the body; it should, therefore, with proper precautions, be quickly banished from our midst. If people will once accept these facts, the spread of the disease might be rapidly checked. One important point to be borne in mind is that this modification of virulence does occur, and for some reasons it is most unfortunate that this should be the case, as in this modified form the attacks of the disease are so mild that they are treated with contempt by those who suffer. On the other hand, it should be remembered that in any disease, if the organisms associated with it are not killed off, their virulence in most instances becomes increased; this appears to be specially the case in influenza. It is this same organism, rendered virulent by its passage through a series of patients, acting on weakened tissues that proves so fatal; but the relation between the milder attacks and the severer forms of the disease has till quite lately been entirely ignored, with the consequence that few precautions as regards isolation and disinfection have been taken, and the disease has been allowed to spread, with the result that the organism from the mild case, finding its way to people of lowered vitality and with little tissue resistance, has set up a severe and often fatal form of the disease.

This tissue resistance is so intimately bound up with the life history of the cell, with its powers of nutrition, and the facilities for excretion of effete matter, with its power of taking up foreign bodies of all kinds, pigment, bacteria, &c., and with its capacity for converting these into inert matter, and afterwards utilising them for its own purposes, or of getting rid of them altogether. It has received special attention since the study of bacteria was recognised, and so much additional knowledge has already been obtained, that we may confidently look forward to a time when we shall be able to predicate what will be the effect of the introduction of tubercle bacilli, of leprosy bacilli, or of other pathogenic organisms, into different parts of the body, where they may be attacked by the different kinds of cells; we shall be able to point out what kinds of organisms are able to bring about degeneration of the various kinds of cells, and whether they do it directly through the action of their protoplasm, through the secretion of poisonous products, or through the presence of their dead protoplasm or of substances contained in it; we shall also be able to state which organisms hunt in couples as it were—the one by its products preparing the way for the advance of the other,—so that where we find it difficult to get rid of both organisms we may be able to deprive one of its power of doing harm by destroying, banishing, or rendering harmless the other; but, more important still, we shall be able to determine the conditions under which the various cells, tissues, and fluids of the body are best enabled to resist the advance and action of these organisms.

Although we are already well versed in the general laws of health, and, theoretically, are ready to meet every kind of disease by which we may be attacked, we have still not arrived at the conviction that, economically, the greater attention paid to the carrying out of mere preventive measures, such as better nutrition for the children of the poor, better conditions of hygiene, greater opportunities for exercise in the fresh air, would be a great saving to the State; whilst any expense that such improved measures might entail would be more than recouped by the great gain to the community as a whole, not merely through the better health and diminished death-rate in our present poverty stricken and overcrowded quarters, but also by the diminution in the number of centres from which disease may spread to those quarters where the conditions of life are much more favourable.

ACUTE CATARRH OF THE LARYNX.

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HISTORY.

ON account of the extremely obvious character of the symptoms of this disease, especially the hoarseness, it would naturally be recognised at an early period in the records of medical science. Through the default, however, of anatomical knowledge, we should not expect it to be differentiated with any degree of accuracy from other throat affections which produce a modification of voice. Before the time of Hippocrates all maladies of the throat were grouped together under the common name of *kynanche*[1] (a strangling or stifling), but later on this term was restricted to internal cases. In the writings of the Asclepiadæ a distinction is first made between those instances in which the internal parts of the throat are visibly affected and those in which the disease is so low down as to be out of sight. In the treatises ascribed to Hippocrates a number of descriptions are given[2] suggesting at one time or another every known form of laryngitis, but none is presented with much pathological discrimination. About 70 A.D. Aretæus[3] apparently coins the word *synanche* to designate acute affections of the larynx, the organ by this date having become known with some anatomical and physiological accuracy. About the same period Cœlius Aurelianus and Galen, especially the latter, treat of laryngeal disease with some precision, and Galen[4] even attempts a description of those maladies which involve the "internal tunic or pellicle" of the larynx. With them we may leave the ancients, and pass through the Middle Ages to the beginning of modern times. Taking Fallopius[5] as a representative of the epoch, we do not find that catarrhal laryngitis is as yet clinically separated from the more serious forms. Only in the middle of the seventeenth century do we meet in Boerhaave[6] brief and definite allusions to the catarrhal varieties. After his time laryngeal disease became more attentively studied, chiefly owing to the researches of Morgagni,[7] who, having met with a striking case in the post-mortem room, afterwards attached great importance to lesions of the larynx. About 1829, in the treatise of Albers,[8] we first have some accurate description of acute catarrhal laryngitis; and nearly at the same time Guersant[9] began to call attention to the malady, as manifested in children, under the name of "pseudo-croup." Finally, with the introduction of the laryngoscope, in the writings of Ruehle,[10] Türck,[11] Gerhardt,[12] and Mackenzie,[13] the general features of the disease were made familiar to the profession.

SEMEIOLOGY.

1. *Subjective.*—At the outset a slight sensation of swelling or obstruction is felt in the larynx, which may be accompanied by more or less perception of abnormal heat in the part. Hence the patient tries to clear his throat by coughing, but with the apparent result of aggravating the disorder. Pricking or stinging sensations are soon developed in the interior of the vocal apparatus, causing the face to become flushed,

[1] Alexander Trallianus, De Arte Med., iv. 1.
[2] Ex. gr. De Morbis, ii., 3, 9; De Victu Acutorum, 4; De Locis, 7, 11, &c.
[3] De Causis et Signis Acut. Morb., i., 7.
[4] De Comp. Medic., sec. Locos, vii., 1.
[5] Obs. Anat. Ventiis, 1563, p. 78 et seq.
[6] Aphorismi, 4th ed., 783–819.
[7] De Sedibus &c., Venet. 1760, Ep. xv., 13.
[8] Die Pathol. u. Therap. d. Kehlkopfkrankheiten, Leipzig, 1829.
[9] Revue Méd., 1829; Dict. des Sc. Méd., 1830, art. Croup.
[10] Kehlkopfkrankheiten, Berlin, 1861.
[11] Klinik der Kehlkopfkrankheiten. Wien, 1866.
[12] Handb. der Kinderkrankheiten, Tübingen, 1868.
[13] Reynolds' System of Medicine, 1871.

and distressing efforts are made to get rid of the inconvenience by coughing. Soon a roughness or soreness, chiefly perceptible in the vicinity of the glottis, results, and the sufferer now begins to refrain from coughing, because it hurts. At the same time a slight stiffness of the throat is felt at each act of deglutition, amounting sometimes to actual pain, which, however, in uncomplicated cases never extends beyond a minor degree. Whilst the disease progresses, hoarseness becomes marked and permanent, and more or less effort is required in order to produce the laryngeal tones. Such, in adults, is the ordinary picture of the establishment of this malady, which most frequently advances thus far within about thirty-six hours. After the first day or two the cough is likely to become spasmodic or involuntary, and accompanied by a limited amount of expectoration. At the same time the slight febrile symptoms, which are present at the outset of the disease, pass away. In a period varying from five to fifteen days, according to the intensity of the attack, the laryngeal symptoms disappear, and the patient regains his usual health. Some weakness or modification of voice, especially in those who make a professional use of the vocal organs, may, however, persist for some weeks, or even months. In children the phenomena of acute catarrh of the larynx are usually invested with certain peculiarities, on account of which it has merited the names of "laryngitis stridulosa" and "false croup." During the daytime the symptoms are usually much less prominent than in the adult. In fact, the existence of the malady is, as a rule, only revealed in the middle of the night, when the patient wakes up in a condition which seems to threaten imminent suffocation. The child suddenly starts up in bed, his breathing is hurried, and accompanied with a sharp, crowing sound at each inspiration; there are frequent accessions of a ringing, convulsive cough. His voice is markedly hoarse, and he speaks with difficulty owing to the urgency of the dyspnœa. This crisis lasts for from twenty minutes to two or even three hours, when the child, becoming somewhat exhausted, again composes himself to sleep. In the milder cases on awakening in the morning he shows scarcely a sign of the severe attack passed through during the night. Generally, however, more or less hoarseness and "croupy" cough continue during the day, whilst the nocturnal phenomenon may return for several nights in succession, though almost invariably with a diminishing urgency.

2. *Objective.*—(*a*) If we examine a case of acute catarrh of the larynx laryngoscopically, we shall usually find very marked evidence of hyperæmia. The vestibule of the larynx is often completely suffused with a vivid redness, whilst considerable swelling is commonly perceived in those parts which contain much loose connective tissue—i.e., the ary-epiglottic folds, the ventricular folds, and the intra-arytenoid fold. At the same time small patches or striæ of a greenish mucus may be observed adhering to the congested surface in various positions. As to the vocal bands, their appearance varies considerably in different instances of this malady. Often they present merely a soiled hue, showing, perhaps, one or two pink spots on their upper surface. In other instances they are decidedly congested, exhibiting a slight but diffuse pink tinge over their whole extent. Sometimes, again, they are so red as scarcely to be distinguished in colour from the adjacent mucous membrane. A proportion of cases are even met with in which an exaggerated hyperæmia of the vocal bands is practically the only objective sign of the malady. In most examples the morbid condition can be observed laryngoscopically to extend for a variable distance down the trachea. When it is strictly limited to the larynx it is generally believed, and probably with truth, that cough is then conspicuous by its absence, but of course voluntary efforts to clear the breath-way are present in all instances. (*b*) As regards expectoration, at first very small quantities of a clear, viscid mucus are brought up, but after two or three days the discharge becomes somewhat more abundant, thinner, and of a greenish hue—in fact, mucopus. Not unfrequently it is streaked with blood, visible macroscopically, and almost invariably blood-corpuscles can be demonstrated with the microscope. Concomitantly pellets of inspissated mucus are expectorated. They are of a greyish or even blackish colour, indicating doubtless that they have remained for some time in the current of inspiration and become soiled by dust or sooty particles drawn in with the external air. If the patient is obliged to breathe habitually with the mouth open, this soiling of expectorated matter by atmospheric impurities is always much more manifest. (*c*) As the hoarseness becomes established the gravity of the vocal tones is generally much increased, but the voice has a great tendency to break suddenly into a higher falsetto note, especially at the beginning or end of a sentence. In females usually, and in males rarely, actual aphonia results, resonant phonation is abolished, and the voice is reduced to a whisper. (*d*) Some local tenderness is present as a rule, so that pressure with the fingers on and about the larynx hurts to a limited extent. (*e*) Respiration is in adults never interfered with to any objective extent. The nocturnal dyspnœa of children suffering from this affection has already been sufficiently described.

Pathogenesis.—Under this heading we have to deal with *predisposing* and *exciting* causes. Among the former the most prominent place must be accorded to youth, for the malady is comparatively rare after middle life. Thus, out of 173 cases of which I have a record, I find 117 were under twenty-five years of age. The male sex also predisposes markedly, only forty-two of these instances being females. The malady is naturally more common in delicate persons, especially those affected with some decided dyscrasia—such as scrofula, tuberculosis, or syphilis. Young persons of this class often have an attack regularly recurring during some part of each winter. Mode of life also favours the occurrence of the disease, and those who are exposed to vicissitudes of weather—such as field labourers, cab-drivers, costermongers, &c.—are more likely to be attacked. As a secondary affection it is frequently met with, and is thus not uncommonly seen associated with scarlet fever, measles, small-pox, typhoid fever, gout, and rheumatism. As to exciting causes, in the first rank stands taking cold by any of the ordinary accidents which lead to exposure. Amongst medical practitioners of the older school a belief very generally prevailed that the kind of cold arising from getting the feet wet, did, as a rule, expend itself in the production of a laryngitis. I have not, from personal experience, been impressed by the efficiency of this etiological factor, but some considerable weight must be allowed to any practical inference which has attained to the rank of a creed amongst a large number of skilled observers. Cases originating in cold are usually met with in damp, chilly weather, such as is most frequent in this climate during spring and autumn. Frosty conditions of weather are less conducive to the disease. Next in order among exciting causes we have those peculiar states of atmosphere which are specifically irritative to the air passages, and are commonly evidenced by the epidemic occurrence of influenza, hay fever, certain forms of coryza, and bronchitis. With such affections a catarrh of the larynx, more or less pronounced, is generally associated. Third on the list we may place instances arising from straining the vocal apparatus, as in loud shouting, screaming from fright, and even inordinate vocal efforts of a professional kind, which, however, are ordinarily linked to laryngeal manifestations of a chronic nature. In this division fall those examples sometimes encountered in females as the sequence of hysterical attacks accompanied by persistent piercing cries. Lastly may be placed those rather rare cases arising from direct irritation of the laryngeal mucous membrane—viz., from inhalation of some irritating gas (chlorine, nitrous acid, steam, chloroform, ether, &c.) or from the contact of a foreign body accidentally finding its way into the larynx, even from the incautious and too frequently repeated introduction of laryngeal instruments for the extraction or treatment of growths &c. In one instance which came under my notice a piece of silver nitrate, becoming detached from the holder, lodged in the hyoid fossa, and in twenty-four hours produced a very violent inflammation of the corresponding side of the larynx; the patient, an old woman, succumbed. With respect to the frequency of the malady compared with that of other diseases of the larynx, no reliable statistics are forthcoming. Here, as in every other department, the annals of special hospital practice show an enormous preponderance of chronic disease. But all such statistics are vitiated by the fact that acute cases comparatively seldom reach the hands of the special practitioner, either in private or at an institution. The specialist, indeed, is nearly always engaged with cases which have previously undergone treatment at other hands. I may say that out of about 6000 instances of laryngeal disease I can collect less than 200 of acute catarrhal laryngitis. Nevertheless I should judge it to be at least three times as frequent as these figures indicate.

(To be concluded.)

TWO CASES OF RUPTURED BLADDER.

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CASE 1. *Extra-peritoneal rupture of the bladder; suprapubic drainage; recovery.*—Miss H. R——, aged twenty-one, was in a railway accident on March 4th, 1890; she had left London at 8.50 P.M. on the 3rd, and the accident occurred at 3.30 A.M. on the following morning. The carriage in which Miss R—— travelled was telescoped, and she says she remembers some heavy weight—she thinks the carriage seat—lying on her abdomen. When first seen shortly after the accident she could not stand or walk on account of pains in the groins and thighs; no fracture or injury to the femora or pelvis could be detected, and there were no bruises or abrasions of the skin. No urine had been passed since leaving London. The patient was suffering from shock and vomited repeatedly. The temperature was subnormal and the pulse small and frequent.—March 5th: No urine having been passed, a catheter was used this morning, and about an ounce of bloody urine drawn off. A few hours later the catheter was again used, and about three ounces of urine obtained, also containing much blood. The patient has recovered from the shock, and complains of great pain in both groins and in the hypogastric region, especially on pressure. No dulness can be detected over the abdomen. Poultices were applied to the thighs and abdomen, and half-grain opium pills administered every two or four hours. The vomiting continues.—6th: To-day there are evident signs of peritonitis, the tenderness being much more marked over the lower than the upper part of the abdomen.—7th: Some slight bruising of the abdominal walls over the bladder was noticed this morning. Urine was passed voluntarily for the first time to-day, and the use of the catheter discontinued. The vomiting has ceased. The urine still contains blood, but in less quantity than two days ago. The patient takes the pills now every four hours. The temperature has varied since the accident from 99·4° F. in the morning to 100·6° in the evening.—10th: Micturition is now very frequent (about every half-hour). In the evening the temperature rose to 102·2°, and the general condition of the patient became more serious. The tongue was dry, coated, and brown, the pulse small and feeble. Only small quantities of milk and beef-tea were taken.—12th: To-day the bowels were moved naturally for the first time since the accident. Micturition is still very frequent and almost involuntary. The urine is clear but contains a sediment of granular matter, chiefly phosphates. The temperature varies from 100° in the morning to 101° in the evening.—14th: To-day a tumour was noticed in the hypogastric region. Dulness was present from the pubes nearly to the umbilicus, and a distinct edge could be felt at the upper limit of the swelling, which was of the shape and appearance of a distended bladder. The tongue is cleaner, but the temperature is still about 100° to 101°. The urine is clear, and contains triple phosphate crystals.—15th: To-day phlebitis was noticed in the right leg, which by the next morning had extended to the femoral vein. The urine now contains pus, and is passed very frequently. During the next week the condition of the patient improved, the temperature remained between 100° and 101°, but more food was taken and the tongue cleaned. The phlebitis gradually subsided. On March 26th phlebitis occurred in the left leg, and the urine contained much pus and was very offensive.—31st: The tumour over the bladder, which had decreased, now began to increase, and deep fluctuation was detected over it. Pain in the abdomen was complained of on April 1st, and vomiting was very troublesome the following day. The temperature ranges from 100° to 102·6°; pulse 120; tongue dry and brown. The patient appears to be getting steadily worse.—April 3rd: Chloroform was administered this morning, and a two-inch incision made over the tumour, just above the pubes in the middle line. About thirty ounces of very foul-smelling purulent urine were evacuated, and a large slough of the size of the palm of the hand gently pulled out of the wound. The cavity was well flushed out with hot boracic acid lotion, a large soft indiarubber tube passed to the bottom of the wound, and brought over the edge of the bed to drain into a vessel on the floor. On exploring the cavity a perforation into the bladder could be felt. It was at the left and posterior part, close to the opening of the left ureter, and just large enough to admit the tip of the forefinger. The edges of the opening were rounded, thickened, and coated with phosphates. The operation lasted an hour and a quarter.—4th: Sickness troublesome all day. Temperature normal; pulse 120. The patient has rallied well from the operation. On the 5th phlebitis of the left brachial and axillary veins occurred; the sickness ceased to-day. The discharge from the wound is very thick, and contains a large amount of tenacious mucus.—8th: All the urine is still passed by the tube. The patient has much improved, and can now retain solid food. From this date convalescence was steady. The urine gradually became clear. The long tube was discontinued on May 8th and the patient removed to the sofa.—June 2nd: The wound has now almost healed. The urine still contains some pus and crystals of triple phosphates.—12th: Wound soundly healed. The patient is well, save that the urine contains a small quantity of pus and triple phosphates and is passed more frequently than natural. In August the patient was quite well and able to resume for some time past her usual habits. The urine could be retained for some hours, and no complaint was made of frequency of micturition.

CASE 2. *Intra-peritoneal rupture of the bladder; suture of the wound; death.*—A man, aged about thirty, was thrown out of his trap at 5.30 P.M., and his companion fell on his abdomen. The patient was not stunned, but for a few minutes felt unable to move; he then got into a passing trap and drove home, about two miles. On his arrival he walked upstairs and got into bed. I saw him at 9 P.M., and he then complained of severe pain in the hypogastric region, and of urgent desire, but inability, to pass urine. I passed a large silver catheter, but failed to draw off any urine. Dr. Lediard saw the case about midnight. The patient did not suffer from shock, had a warm moist skin, a full soft pulse, and had so little idea that he was seriously injured that he said he should go out again as soon as we had emptied his bladder. He assured me that he had passed urine freely about half-an-hour before the accident, and that he had never had any difficulty in micturition before. There was a distinct fulness above the pubes, and some dulness in the same region as if from a distended bladder. Under chloroform, about a pint and a half of bloody urine were drawn off by means of a lithotrity evacuator and aspirator. Next morning we found the patient sitting partially dressed in his dining-room; after some persuasion we induced him to return to bed, and again removed a quantity of urine by the evacuator. A catheter was first passed, but no urine could be drawn off. The patient now showed evident signs of a serious internal injury; his expression was anxious, his pulse small and thready, and his abdomen distended. The diagnosis was clearly a ruptured bladder. Mr. Page of Newcastle saw the case in the afternoon and, when the patient had been placed under an anæsthetic (a mixture of chloroform and ether), made an abdominal section. The bladder was found collapsed behind the pubes. There was a star-shaped rent about two inches long on the posterior surface opening into the peritoneum. This was sutured with catgut, but the patient died before the operation was completed. The peritoneum contained a large quantity of blood-clots and urine, and showed signs of commencing peritonitis.

Remarks.—The first case was perhaps as clear a case of ruptured bladder as could be seen, for almost all the symptoms in turn were present. The slough that was removed at the operation, when subsequently examined, was found to consist chiefly of mucus and phosphate crystals. The bladder must have ruptured close to the entrance of the left ureter. In the second case the history was certainly misleading, for if the bladder had been empty the injury present could not, I believe, have occurred. The patient had been drinking freely, and if he had recently emptied his bladder there was no doubt it must have contained a considerable amount of urine at the time of the accident. Shock was not present till some hours after the accident, and till then we thought that the bladder was merely contused and filled with clotted blood.

The above cases occurred in the practice of Dr. Lediard, F.R.C.S. Eng., Surgeon to the Cumberland Infirmary, and I am indebted to him for permission to publish them.

Haverfordwest.

THE MECHANISM OF DELIVERY OF THE FŒTAL HEAD IN VERTEX PRESENTATIONS; ALSO THE PERINEUM IN LABOUR AND ITS MANAGEMENT.

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ALTHOUGH I have chosen "Mechanism of Delivery of the Fœtal Head" as the title of this paper, some of the remarks I have to offer will be applicable to all kinds of presentation. I propose, under mechanism, to consider "rotation" and "extension." As the former process takes place in exactly the same way and at the same place, whatever the presentation of the fœtus, the causes giving rise to it must be identical in every case. Having discussed "rotation," I shall take up "extension" of the head, described as invariably occurring during the birth in vertex presentations, in which the occiput has rotated forwards to the pubes, and shall adduce reasons for rejecting the idea that extension plays any part in the delivery of the head, pointing out at the same time that, did it occur, it would be a process of extreme disadvantage to the mother. In conclusion, the function of the perineum in labour having been noted, the method for preserving it, based upon observation of its behaviour and that of the head during parturition, will be described, and the results obtained in fifty cases of labour detailed. In attempting such a task as the above, I am fully aware that I shall be giving utterance to opinions directly opposed to those held by the authors of standard text-books of midwifery, and therefore contrary to ideas widely prevalent in the profession. Whether I shall succeed in proving my own case or no, I trust at least I shall be able to bring forward sufficient evidence to show that the explanations at present received of the mechanism of delivery will not bear a careful scrutiny, and for this reason are well worthy of being thought out afresh.

Rotation.—On reading the explanation of the mechanism of rotation as described in various text books of midwifery, one point has always forced itself on my attention—viz., that writers invariably account for the process by reasons which completely exclude the soft parts from any important share in the operation. Thus, to quote Lusk[1]: "In either of the occipito-anterior positions rotation is not difficult to understand. The convergent anterior inclined planes furnish smooth surfaces upon which the occiput glides downwards and forwards to the front. The rigid ischial spines direct the forehead to the sacro-sciatic ligaments, which determine the backward movement corresponding to that of the occiput in the front part of the pelvis." The smooth inclined planes of the pubes and the ischial spines are here assumed to be the prime factors in bringing about a change in the position of the head from the oblique to the antero-posterior diameter at the outlet; and with this view those of other authors substantially agree. To this explanation several objections suggest themselves: 1. Internal rotation of the head is effected by torsion of the neck of the child, the trunk hardly participating at all in the movement. The head is kept in this constant state of twist until after delivery, when untwisting or "restitution" takes place. This continued state of torsion requires that there shall be a constant force holding the head in position *nolens volens*. Even supposing the inclined planes of the pubes and the ischial spines capable of favouring rotation, they would certainly be incapable of opposing the necessary resistance to maintain the head in its distorted position, and prevent it unwinding. For between the ischial spines and the centre of the sacrum, into which the forehead rotates, there is a considerable space where the head would be free to move from side to side. If the ischial spines have any function at all they can only oppose a merely passive resistance to the forehead getting anterior to them, but they are utterly powerless to actively press it back into the sacrum and hold it there. If what I have said respecting the necessity for a constant force acting on the head to maintain it in the position of torsion be true of occipito-anterior presentations, it is still more true in the case of occipito-posterior positions, where the occiput in rotating forwards is twisted through three-eighths instead of one-eighth of a circle. Moreover, in breech presentations an actual twist of the trunk occurs at the outlet—a displacement which, considering the rigidity of the fœtal structures involved, and therefore the resistance that would necessarily be opposed to the movement, would, it seems to me, require something more than the favouring influence of the inclined planes of the pubes and the projection of the ischial spines to bring about and maintain. 2. In executing the movement of rotation, the head from lying in a diameter of 4¼ in.[2] (transverse) passes into one of 3⅞ in. (conjugate) at the outlet. It is only rational to suppose that any resistance which the bony parts might be likely to oppose, were they the sole agents to be considered, would be directed to the prevention rather than to the encouragement of a change by which the head, judging from the relative diameters of the bony pelvis, apparently assumes a position of disadvantage and deliberately hinders its own progress. Had the head only the bony pelvis to traverse, such an alteration in its direction certainly seems strange and unnatural. I shall presently have occasion, however, to point out that the movement, looked at by the light of the anatomy of the soft parts of the female pelvis, is not only not strange, but is the best possible that could be done under the circumstances.

In the causation of rotation Dr. Galabin[3] attributes much importance to the gradual narrowing of the pelvis from brim to outlet, and considers that the head rotates into the antero-posterior diameter, because the latter is the longest at the outlet, while the influence of the inclined planes, he believes, has been much exaggerated. The average relative diameters at the outlet Dr. Galabin gives as—transverse, 4 in.; antero-posterior, 3·5 in.; the latter being increased by extension of the coccyx to 4·5 in. Surely, it is scarcely fair to assume that the head by rotating forwards will exchange a pelvic diameter of 4 in. for one of 4½ in., seeing that the latter is not produced until the head is forcing its way through the lower pelvic strait after rotation is complete. To make such an assumption appears to me a *post hoc propter hoc* method of arguing. I presume it is agreed that rotation in the majority of cases takes place before the occipito-frontal diameter begins to come through the outlet, and therefore at a time when the antero-posterior diameter is still only 3½ in. I am borne out in this view by Lusk,[4] who says, "When, however, rotation is completed, the bi-parietal diameter (3⅞ in.), which is capable of sustaining a considerable degree of lateral compression, engages in the transverse diameter of the pelvis; at the same time the suboccipito-bregmatic engages in the conjugate. The latter, though measuring but 3⅜ in., may be extended to 4½ in. by the pressing backward of the tip of the coccyx." If anybody will make the experiment on a dry pelvis of putting the fœtal head through the outlet—first in the transverse and then in the conjugate diameter—he will quickly assure himself that, despite the narrowing which has taken place from brim to outlet, the advantage is still decidedly on the side of the transverse diameter, and that the gain to the head by veering round into the conjugate is, so far as the bony canal only is concerned, a very dubious one. 3. My last objection to the theory that the inclined planes of the pubes favour rotation forwards is this: From the moment that the head engages in the pelvis up to the time that it descends to the bony outlet it is in constant relation to the pubes. Now it is only right to infer that had the latter any marked directive action on the occiput, that action should continue during the whole time that the pubes remained in relation to the head. In other words, rotation on this hypothesis ought to keep pace with descent, and not, as actually takes place, be delayed till the presenting part has reached the outlet. Here the change in direction invariably occurs, and oftentimes suddenly, showing that the lower pole of the fœtus comes into relation with some more powerful rotatory force than the inclined planes of the pubes. What this force is can only be under-

[1] Lusk's Midwifery, p. 173.

[2] Lusk, p. 151. These diameters correspond in length with those of a female pelvis in the osteological collection of the Medical Society of University College, London.

[3] Galabin's Midwifery, pp. 14, 15.

[4] Lusk's Midwifery, p. 173.

stood by a reference to the anatomy of the pelvis, for which purpose I here introduce a diagram of a vertical section passing through the ischial tuberosities, and looked at from behind. The points in the drawing to which I wish to direct particular attention are the following:[5]—(*a*) The recto-vesical fascia, which forms, together with the levator ani, an oblique diaphragm across the pelvis, attached in front to the pubes, laterally to the obturator fascia, and behind to the ischial spines. The recto-vesical fascia, and with it the levator ani, may be looked upon as a septum passing obliquely across from the junction of the anterior wall of the pelvis with an imaginary ceiling to the junction of the posterior wall with an imaginary floor; while its lateral attachments are two

FIG. 1.

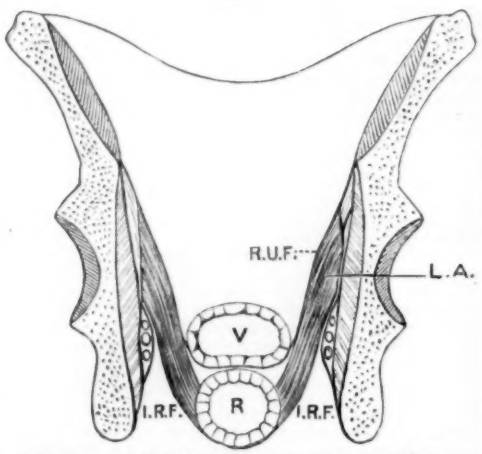

Diagram of a section through the female pelvis. V, Vagina. R, Rectum. I R F, Ischio-rectal fossa. R V F, Recto-vesical fascia. L A, levator ani.

diagonals (the so-called white lines) drawn from the anterior and upper to the posterior and lower corners of the side walls. From its attachment to the side walls of the pelvis the recto-vesical fascia passes downwards and inwards to form sheaths for the bladder, vagina, and rectum. From this description it is evident that the floor of the pelvis presents two very marked slopes, one downwards and backwards, from pubes to ischial spines and sacrum; the other downwards and inwards, from the side walls of the pelvis to the various structures passing through the floor. I shall presently point out what I believe to be the significance of these two slopes in determining the movements of the fœtal head. (*b*) Between the pelvic diaphragm and the side wall of the pelvis on each side is the irregular wedge-shaped space, the ischio-rectal fossa, which at its base is an inch wide, and at its deepest part behind runs up the side of the pelvis for a depth of two inches. These spaces are completely filled with fat. (*c*) Covering the inner surface of the lateral walls of the pelvis are the obturator interni muscles. From all this the point clearly apparent is that below the level of the white line or upper insertion of the pelvic floor the transverse and oblique diameters of the pelvis become rapidly smaller and smaller, being encroached upon by the pelvic diaphragm and ischio-rectal fossæ to a far greater extent than by the gradual slope of the bony wall from brim to outlet; while, on the other hand, the antero-posterior diameter at the outlet preserves its length unaltered—that is to say, the conjugate at the outlet, from being the smallest diameter in the dry pelvis, becomes in the living body the longest. The pelvic diaphragm being composed of strong fascia and muscle, and the space between itself and the pelvic walls being filled in with fat, the extent to which the transverse and oblique diameters can be enlarged by compression and distension of soft structures must be comparatively slight.

The bearing of these anatomical points upon the path followed by the presenting part through the pelvis is evident. Taking the left occipito-anterior presentation for an example, we see that the head descends in the oblique diameter until it comes into relation with the sloping pelvic diaphragm. As pointed out above, the longest diameter of the pelvis available for the child now changes to the antero-posterior. The longest diameter of the fœtal head lying athwart the antero-posterior or longest diameter at the outlet, if further progress downwards is to be made, must turn into the conjugate; while the transverse or narrowest diameters of the fœtal skull accommodate themselves to the smallest or transverse diameters of the pelvis. In this rotation the occiput, being nearest the pubic arch and the lowest part of the advancing fœtus, naturally turns forwards in the line of the least resistance. It will further be seen that the state of twist of the neck of which internal rotation consists is not only brought about, but is kept up by the pressure which the sides of the pelvic diaphragm exercise. As the pelvic floor reaches down to the outlet the torsion of the head cannot be undone until it has escaped from the vulva. No theory purporting to be an explanation of rotation would be complete until it had also accounted for cases such as occipito-posterior presentations, in which the occiput, instead of taking the shorter course of rotation backwards, prefers the longer one of rotation forwards. The movement is usually accounted for by the statement that[6] "if the anterior wall (i.e., of the pelvis) be divided by a line drawn on a level with the lower margin of the symphysis, we find that in the superior division the general pelvic pressure diminishes from before backward, while below the line indicated pressure diminishes from behind forward." This greater pressure in front at the brim of the pelvis, acting at a superior mechanical advantage on the forehead, turns it backward, the occiput consequently coming forward to the pubic arch. No doubt the statement that the pressure in the lower part of the pelvis is greater at the back than in the front is true; but I am at a loss to understand on what the proof of the first portion depends. The upper plane of the pelvis being enclosed by a bony margin all round, I do not see how one portion of bone in front is capable of exercising a greater pressure than another piece of bone behind. Moreover, even supposing that this greater pressure really existed in front at the brim, it could manifest itself only as a passive resistance to the forward rotation of the forehead—a vastly different thing from an active driving force such as it must be if it is capable of pressing the latter back into the sacrum. Plainly, in order to fit in with a theory, passive resistance has been made to do the work of an active pushing force. Again, if it be correct that there is a difference in pressure between the anterior and posterior sections of the upper portion of the bony pelvis sufficiently great to drive the forehead back into the sacrum, it ought also to be capable of producing something requiring a very much smaller effort—viz, tilting up of the head towards the posterior shoulder. For on this hypothesis the anterior parietal bone must be constantly subjected to a greater pressure than the posterior, a result which can only terminate in one way—viz., by producing lateral obliquity of the head at the brim—a movement which it is pretty generally agreed does not occur in the normal pelvis.

It appears to me that the forward rotation of the occiput in occipito-posterior presentations may also be explained by appealing to the anatomical conditions which obtain in the pelvis. I have pointed out above that the pelvic floor presents two slopes—(1) downwards and inwards, narrowing the transverse and oblique diameters; (2) downwards and backwards from the pubes in front to the ischial spines and sacrum behind. In occipito-posterior presentations at the time that rotation of the occiput is going to occur forwards the head is in the following position: It is well flexed, the occiput is opposite the sacro-iliac articulation, and is the most dependent portion of the fœtus; while the forehead and face are turned towards the opposite acetabulum. As the uterus contracts the occiput, being the lowest part, is forced down first into the narrowest portion of the pelvis, and has the benefit at the outlet of the greater resistance behind opposing its rotation backward. On the other hand, the forehead, if it has to come forward, must move up the inclined plane of the pelvic floor, and therefore against a much greater resistance than it

[5] Godlee's Anatomy, p. 221.

[6] Lusk, p. 174

would do if it went backwards along the downward slope of the pelvic diaphragm. At the same time this resistance would be experienced along the whole length of the inclined plane, and, as it is directed against the long arm of the lever, would act at a greater mechanical advantage. The result is that as the uterus contracts and forces the child down, it is easier for the occiput to come forwards than the forehead, and consequently forward rotation of the former takes place. Should the head, however, not be completely flexed, the mechanical advantage on the forehead is lost, and the occiput goes back into the sacrum. After the birth of the head the vulva shrinks, the perineum retracts, and the anus contracts. On the pains recommencing, the shoulders descending in the opposite oblique diameter to the head are rotated forwards as they are forced down on the floor of the pelvis just in the same way as the head. Rotation of the shoulders always takes place on the pelvic floor, and usually rapidly.

(To be concluded.)

EPISTAXIS: AN EASY AND EFFECTUAL METHOD OF PLUGGING.

BY A. A. PHILIP, M.B., C.M. ABERD.

UNDOUBTEDLY plugging the nares by aid of Bellocq's cannula is an excellent method; but occasionally, especially in country practice, a Bellocq's cannula is not at hand, and some method easy, effectual, and effected by material always within reach, must be resorted to. Such a method I have found in the following. A piece of old, soft, thin cotton or silk, or oiled silk, about six inches square (a piece of an old handkerchief will answer) is taken, and, by means of a probe, metal thermometer case, or penholder, or anything handy, is pushed centre first, "umbrella" fashion, into the nostril, the direction of pressure when the patient is sitting erect being backwards and slightly downwards. It is pushed on in this fashion until it is felt that the point of the "umbrella" is well into the cavity of the naso-pharynx. The thermometer case or probe, or whatever has been employed, is now pushed on in an upward direction and then towards the sides, so as to pull more of the "umbrella" into the naso-pharynx. The thermometer case is now withdrawn. We have now a sac lying in the nares, its closed end protruding well into the pharynx behind, and its open end protruding at the anterior opening of the nares. If it be thought necessary, and is convenient, the inside of the sac may be brushed with some household astringent, such as alum solution, turpentine, &c. A considerable quantity of cotton wool is now, by means of the thermometer case, pushed well back to the bottom of the sac. Then, the thermometer case being held firmly against the packed wool, the mouth of the sac is pulled upon, and thus its bottom with the wool packed in it is pulled forward, and forms a firm, hard plug wedged into the posterior nares We may now pack the sac full of cotton wool, dry or soaked in some astringent solution. The mouth of the sac may now be closed by tying it just outside the nostril with a piece of strong thread; it is then trimmed by scissors and the ends of the thread secured outside.

The above method is easier than any I know when both nostrils have to be plugged. It might be suggested to oil the cotton or silk in order to render its introduction easy and to prevent it adhering to the mucous membrane, and to render it easy of removal; but I have never found any difficulty without the oil, as the blood renders the material wet and easy of introduction, while the oil does not facilitate removal, and may modify the effect of the astringents that may be used. The plug may remain *in situ* as long as any other nose plug. In removing the plug, open the mouth of the sac, and with small dressing forceps remove the cotton wool bit by bit; if there is bleeding simply syringe the sac with weak carbolic lotion or Condy's fluid and repack with clean cotton wool, or wool impregnated with some antiseptic. If there is no bleeding when the wool is picked out, gently pull out the sac; or if it be adhering to the mucous membrane, syringe in a little warm water, and it may then easily be removed. This method has many advantages. (*a*) It is easy, quickly accomplished, and effectual, and the materials are to be found in every house, and, indeed, about everybody's person (I have plugged in this manner, simply using a handkerchief, one part of which was used for the sac, and the other, torn into narrow strips, in place of the cotton wool); (*b*) no damage is done to the floor of the nose or back of the soft palate by strings &c.; (*c*) no disagreeable hawking, coughing, or vomiting takes place while the plug is introduced; (*d*) there are no disagreeable strings left hanging down the throat, causing coughing or sickness while the plug is in; (*e*) the plug can be removed gently without any force, so that no damage is done to the mucous membrane and no return of hæmorrhage caused. I employed this method frequently when in country practice, and do so now in bleeding after operation on the nares, and have always found it to be satisfactory. As the method has been of great use to me, and as I am not aware that anyone has spoken of it before, I take this opportunity of mentioning it, in the hope that it may be of use to some brother practitioner when confronted by an urgent case of epistaxis, and other means of plugging are not at hand.

Belfast.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

DIVER'S PARALYSIS.

BY P. W. BASSETT-SMITH, Surgeon R.N.

WHILE on board H.M.S. *Penguin*, employed in surveying a part of the north-west coast of Australia, which was then an important centre of the pearl oyster fishery, several cases of this disease came under my notice now and then. The luggers contain about six men, mostly Japanese, occasionally Europeans, and are accompanied by a schooner which acts as a store and hospital ship. They are away many months at a time, sometimes a year; the food supplied was good. All the work was done in diving dress in depths of from ten to twenty-five fathoms, the period of submersion being often four or five hours. Cases of slight paralysis were common, coming on suddenly on removal of the dress, but generally recovering completely. The following is the worst case I saw:—

Sept. 5th.—Japanese, aged about thirty. Had been working in thirty-two fathoms (by all considered to be a dangerous depth) about three weeks ago; immediately on removal of the dress he became suddenly paralysed, and has been so ever since. His condition was one of great emaciation, free from pain, but very apathetic. Temperature 103°; pulse 120; tongue furred; complete paraplegia, with loss of control of bladder and rectum, and loss of sensation to the level of the umbilicus. There was a large deep bedsore over the sacrum extending from the tuber ischii on either side to the crest of the ilium above, with a thick, black, extremely offensive slough partially detached; it had eaten through skin, fascia, and gluteus maximus, and in places exposing the bone; there were also small sores over the ankles and knees. He had had a catheter passed twice a day, castor oil once a week, poultices and strong carbolic lotion to the sore, good diet, and port wine.—7th: No marked change. Temperature 103°.—8th: Refusing food; diaphragmatic spasm; moribund; died at 4 P.M.

This was no doubt a case of severe hæmorrhage into the lumbar centre of the cord, with subsequent myelitis, death being due to septic poisoning. The mate attending on him stated that he had been as bad himself with bedsores and paralysis for eight months; he now walks with a limp, but muscular power is fair and tissues firm, knee jerks increased. He said that a very bad sign is a localised swelling of the abdomen, from which, if allowed to get under the ribs, death is certain, and that they apply any pressure to keep it down, even "sit on it," probably a paralysis of intestinal muscles and collection of flatus. Those in charge told me that they

try to prevent men going down over twenty fathoms, but as they are paid by results it is very little use.

Admiralty Gulf, N.W. Australia.

CASE OF RUPTURED HEART.

By E. ROUSE ROUSE, M.R.C.S., L.R.C.P. LOND., L.S.A.

A. B——, aged fifty-two, a stout and plethoric-looking man, while playing football, suddenly and without warning fell down in a sort of faint, but soon recovered and continued to play until the close of the game, never at any time, however, really over-exerting himself. After the game was over, and while returning to the ward, he was again seized with a somewhat more severe fainting fit, and accompanied this time by severe pain in the cardiac region. I saw the patient about ten minutes after this, and found him somewhat collapsed, with an almost imperceptible pulse and very shallow breathing, and complaining of excruciating pain in the cardiac region. He was ordered to bed, hot fomentations were applied over the cardiac region, and he was given hot brandy-and-water at short intervals, followed by a sedative draught; he was then seized with violent sickness, and said he felt somewhat better. He was kept in bed for two days, and placed on milk and beef-tea; and as then his symptoms had disappeared, he was allowed up, but he was not to walk about the ward. He continued in this state up to the date of his death, exactly a week after, on which day he had another fainting fit, and died in less than five minutes. At the necropsy was found a complete rupture of the left ventricle, about half an inch in diameter. The pericardium contained twelve ounces of blood-clot, besides some blood mixed with a serous fluid. The heart substance was very friable and fatty degenerated, as were also most of the other organs.

The interest in the case arises from the fact that the man lived exactly seven days after the date when we may assume the rupture partially occurred, or otherwise how are we to explain the severe symptoms complained of? But it is difficult to understand how he lived so long, unless we presume that, on the day when he was seized with his severe symptoms, the rupture was incomplete, or so small as not to allow the escape of blood into the pericardium, but that on the date of his death a sudden exertion or an increased pressure of blood ruptured more completely the previous injury, and as a consequence the immediate rush of blood stopped the heart's action, which undoubtedly was the cause of death. I should be glad to hear of anyone who has had similar cases, though I find in Bristowe's Medicine patients having lived a few hours or even a few days, but never as long as a week. The above case is, I think, of sufficient interest to be worthy of record.

Colney Hatch Asylum, New Southgate, N.

HÆMATOMA OF VULVA POST PARTUM.

By FRED. W. MANN, M.B.,

LATE HOUSE SURGEON TO THE SIMPSON MEMORIAL AND MATERNITY HOSPITAL, EDINBURGH, ETC.

MRS. H——, residing in Huddersfield, aged thirty-four years, multipara (married sixteen years), seven labours and three miscarriages. The patient always enjoyed good health during her married life, is above an average-sized and a strong-looking woman. Last miscarriage four years ago; youngest living child nearly three years old; last menstruated about Sept. 5th, 1890. All her labours, with the exception of the first, were pretty easy, the last being very easy. I was called to see Mrs. H—— on Sunday, May 17th, 1891, at 8.30 P.M. On vaginal examination the following was made out: Head at pelvic brim, os well dilated, and membranes almost down to vulva. I ruptured the membranes, and the head descended and presented; in about an hour the labour was completed without any further assistance. I inspected the perineum, which I invariably do, and it was not in the least injured. I gave her a drachm of ergot by the mouth, washed and bound her up, and after taking the pulse, which was about 90 per minute, left. About 3 A.M. the same night the husband came for me, and said that something had come down; he thought it was the womb. I refused to go, being absolutely sure the uterus could not by any possibility have become prolapsed. After a little while the daughter came for me crying, and said that her mother was dying. On my arrival the patient was perfectly blanched, sighing, gasping for breath, vision obscured, and picking at the bedclothes. On visual examination a swelling the size of a man's skull was observed between the thighs, which was a hæmatoma of the left side of the vulva. I applied a cold antiseptic cloth, and went for Dr. Macgregor, whose patient she was, and whom I was assisting at the time. We went back together immediately, to find that the patient had burst the sac and was lying in a pool of blood. Dr. Macgregor examined her quickly, and confirmed my diagnosis. He then increased the rent, turned out the clots, syringed the cavity with hot antiseptic lotion, and plugged with sterilised gauze. Brandy and soda-water and milk were freely administered. The plug was removed twenty-four hours after, and not replaced. Subsequently she was syringed out by me twice daily with sublimate for ten days, and then continued it herself. She recovered without a bad symptom, and without a rise of temperature.

Remarks.—The following are worthy of note: The easy labour, the bursting of the tumour, antiseptic efficiency in midwifery, and recovery. My apology for publishing the case is its rarity, and its occurrence oftener in easy labours than those in which instruments are used.

Mortimer-street, W.

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

ST. THOMAS'S HOSPITAL.

EXCISION OF THE ILEO-CÆCAL VALVE FOR CARCINOMA; SUBSEQUENT OPERATIONS FOR FÆCAL FISTULA; RECOVERY.

(Under the care of Sir WILLIAM MAC CORMAC.)

THE case we here record is one which presents many features of interest. Although chronic intussusception is more common in adults than in children, and in the situation in which it appeared here than in other parts of the intestine, it is rare to find a malignant growth forming part of the tumour produced by the intussusception and apparently the cause of it. The cases of resection of intestine for malignant disease hitherto recorded are but few, and of these success equal to that obtained by the operations in this patient has seldom been achieved. The question as to the best method of treating malignant disease involving the large intestine is one which must be decided at the time the individual sufferer applies for relief. Sometimes the symptoms of obstruction are too urgent, the general condition too bad, to permit of any prolonged operation; the growth has too many adhesions to surrounding parts to allow it to be brought to the surface, or there are considerable secondary deposits. In these cases the formation of an artificial anus is desirable. When the circumstances are as favourable as they appear to have been here, the operation of resection presents advantages offered by no other method. It will more especially meet with favour in similar cases should it ultimately appear that immediate suture after the resection can be done with equal or greater safety than the resection, formation of artificial anus, and the serious operation for the closure of the latter. Hahn's statistics were in favour of the performance of the operations in two stages. Senn has recorded two cases of resection of the cæcum for carcinoma in which he employed his decalcified bone plates. One of these was a success; the other died from ulceration of the intestine. We hope it will be possible to give the ultimate result of the operations on this patient. For the notes of the case we are indebted to Mr. H. B. Robinson, late resident assistant surgeon.

E. O——, aged thirty-six, a blacksmith, was admitted into the hospital on Nov. 29th, 1890. There was no history

of cancer in the man's family, and until the present illness the patient had enjoyed good health. Five months before admission he was suddenly seized with violent griping pain in the umbilical region, which lasted for one day; this was followed by a similar attack one month later. The attacks then became more frequent, occurring every week, and occasionally oftener. During these attacks, which came on without any obvious cause, he felt a lump in the right inguinal region, which enlarged towards the epigastrium and dispersed with gurgling. The motions passed during the attacks were of a dark colour, and sometimes contained blood. Sometimes during the attacks he suffered from diarrhœa. In the last four months the man had lost fourteen pounds in weight. The abdomen on examination proved to be thin and retracted. A lump was to be felt in the right iliac region, tender on palpation, which produced slight gurgling. On Dec. 2nd, 3rd, and 4th he had attacks of pain with increase in size of the tumour. On the last date there were considerable diarrhœa and copious discharge of blood.

Under chloroform, on Dec. 7th, a slightly curved cylindrical tumour, with concavity downwards, elastic and resistant, was felt. Two-thirds of the growth were to the right of the middle line, and its lower border was on a level with the umbilicus. The swelling could be moved about with the fingers, mostly in a direction transverse to the long axis of the tumour.

Dec. 10th.—Abdominal section was performed by Mr. Sydney Jones, by an incision about five inches long in the linea alba. The tumour was found to be an intussusception of the ileo-cæcal form. This was easily reduced, except close to the valve, where firm adhesions had formed, which had to be broken down. The valve itself was greatly thickened, and the lips were covered with papillomatous growths. The cæcum, with adjoining parts of large and small intestine and a V-shaped piece of mesentery, was resected, and the open ends of the intestine were attached to the abdominal wound to form an artificial anus, the opening into the large intestine occupying the higher position. The growth was examined and pronounced by Mr. Shattock to be carcinoma.

From this operation the man rallied well and made satisfactory progress. On Dec. 25th he had two syncopic attacks, but they were not repeated, and nothing further retarded his convalescence. Owing to the very great annoyance from the fæcal discharge from the artificial anus and from the extensive excoriation of the surface produced by it, and from the absence of any return of the growth, it was decided to restore the lumen of the bowel. This was done on Feb. 20th, 1891, after having well flushed out the intestinal tract with warm boracic fluid.

The two ends of the gut having been well washed with boracic acid, and the surrounding skin with 1 in 5000 perchloride of mercury, two small sponges with strings attached were inserted in the openings into the intestinal canal. An incision was made along the old linear cicatrix above and below the openings, and the two wounds thus formed were joined by incisions on either side of the artificial anus. By careful dissection the ends of the intestine were separated from the adhesions, the small intestine being first freed, and subsequently the large. Two stout ligatures were now tied round the ends just external to the sponges, to prevent any escape of their contents, and after further separation each end was clamped on the proximal side of the sponge, and the latter withdrawn. The ends of the intestine were now trimmed up, so that the attachments of the mesentery corresponded with their cut ends. The cut edges of the mesentery, after the insertion of Senn's circular indiarubber ring into the small intestine, were brought together with fine silk interrupted sutures. An attempt was now made to invaginate the small into the large intestine (Senn's circular enterroraphy), but this did not succeed very well, especially at the posterior part, and the circular ring tended to collapse. Lembert's sutures were accordingly used to complete the junction until the two ends were firmly united all round. During the suturing a sponge was placed in the abdominal cavity, to prevent any contamination by fæcal matter, but nothing whatever escaped from the intestine. The clamps were now removed; and the intestinal loop having been washed over with a 1 in 5000 perchloride of mercury solution, was returned into the abdominal cavity so as to rest just beneath the wound. The external incision was then closed. At 11 P.M. he complained of thirst; slight hiccough. At midnight his pulse was 80, and temperature 97·4°. Tongue dry and parched, and he was ordered to rinse it out with water. No discharge from wound. Rather restless. A quarter of a grain of morphia given hypodermically.

Feb. 21st.—8 A.M.: The patient slept fairly well after the injection; temperature 97·6°; he complained of slight pain in the abdomen. He was given a teaspoonful of water to drink from time to time. 8 P.M.: Had another injection during the day, as pain is still present. Dozed on and off. Passed twelve ounces of urine. Temperature 99·2°; pulse 86.

22nd.—8 A.M.: He had a much more comfortable night, having slept fairly well, and very little pain. Not so thirsty. Temperature 99°; respiration regular. Sixteen ounces of urine were passed, loaded with lithates. Has passed flatus. 8 P.M.: Had some sharp pain at intervals during the day, but slept on and off. Allowed small quantities of barley water, beef-tea, and brandy. Temperature 99·8°; pulse 80. There is no pain this evening.

23rd.—He has been restless and thirsty during the night. Temperature 98°. 8 P.M.: Has been coughing during the afternoon, and been restless and irritable, complaining still of thirst. Slept at intervals. Temperature 100·8°; pulse 84. Passed twelve ounces and a half of urine. No complaint of pain.

24th.—8 A.M.: The patient has had a very good night, sleeping most of the time, without any pain. Temperature 98·4°. 8 P.M.: Fretful and restless, complaining of pain and of the tightness of the bandage. Some cough. Temperature 100·6°; pulse 86. Tent and steam-kettle ordered. At midnight the temperature was 102°, with profuse sweating.

25th.—8 A.M.: He complains of some pain in the left side. Temperature 100·2°. Bowels acted slightly (about three ounces) for the first time, and has passed large quantities of flatus. Complains of being in pain in the lower part of the bowel. 8 P.M.: Bowels slightly open again. Very comfortable during the day. Temperature 99·4°. Ordered one drachm of port wine every two hours.

26th.—Good night with no pain. Temperature 99°. 8 P.M.: Temperature 100·6°; pulse 100. Bowels opened at 6.30 P.M., and about three ounces of partially formed motion passed. At 10 P.M. a bad smell was noticed from the wound, and on the dressings being removed they were found to be saturated with dark fæcal matter. The sides of the wound had separated about half an inch, and at the bottom, about the middle of the incision, there was a small opening into the gut, from which fæces came out.

27th.—Temperature 98·4°. Passed a good night. In the evening slight action of the bowels per rectum. Temperature 101·6°.

28th.—Very restless night; complaining of pain in the right side. The stitches were all taken out and strapping applied. Fæcal discharge from fistula free. For the last two days milk has been given. Temperature 101·4°.

March 2nd.—Not quite so well owing to slight pneumonia. Temperature 102·4°. Passed a motion per rectum.

3rd.—Better, but temperature still up to 101°. Another motion per rectum; discharge from fistula about the same.

4th.—Two more motions per rectum. Temperature only 99°, and much better.

7th.—During the last twenty-four hours the patient has passed more per rectum. The fistula, however, still discharges, but in less degree. The wound remains open, and at the bottom of it a tongue of granulations protrudes towards the right side, at the apex of which is the opening of the sinus. The indiarubber tube has not yet been passed. Temperature normal.

16th.—Since the last note the patient's abdomen has been tightly strapped. Very little has come from the fistula, which is smaller, and the wound itself has healed considerably. He has had at least one action of the bowels per diem. Cough practically gone. Some œdema of right leg.

30th.—Fistula very much smaller, the everted mucous membrane filling the opening. There is very little fæcal matter passed through it.

April 7th.—Fistula still smaller. Strapping left off.

15th.—A plastic operation was done for the closure of the fistula. Sir William Mac Cormac marked out two flaps, one on the left side extending upwards for three inches and a half from close to the fistula, and being about one inch wide, and the other on the right side of equal size, but pointing downwards. After raising the flaps, which consisted of skin and subcutaneous tissue, the upper or left flap was brought across the abdomen and placed below the lower or right flap. The edges of the flaps were then sutured together,

as well as the edges of the wounds from which they had been raised. After the suturing the fistula was completely covered in. Iodoform dressings were used.

16th.—No fæcal matter has made its appearance. Some slight serous discharge from the wounds. The right flap looked somewhat blue. Patient very comfortable.

17th.—Since the operation there has been no action of bowels. A good deal of fæcal matter has made its way between the lips of the flaps. Right flap still discoloured.

21st.—Sutures removed from wounds from which the flaps were raised. Skin separating from the right flap, the edges of which are blue.

24th.—Remaining stitches taken out. About one inch of the right flap is sloughy, but has not yet quite separated. Fæcal matter still passing. Rest of the wound appears very healthy.

28th.—Slough separated.

30th.—No fæcal escape for the last two days.

May 1st.—As the right-hand flap had sloughed along its upper or left-hand margin, and thus was giving no support over the position of the fistula, the skin above the flaps was dissected up for a short distance, and its edge brought down and stitched to the upper edge of the right flap remaining.

5th.—All stitches removed.

11th.—Slight escape from fistula.

19th.—No fæcal matter passed since the 16th. Allowed to get up.

29th.—On coughing last night a little fæcal matter escaped from the fistula, and the same happened this morning.

June 1st.—Discharged from hospital with slight fæcal discharge from time to time.

About six weeks after leaving hospital the patient wrote to say that for the last few weeks there had been no discharge, and that the wound was quite soundly healed. In October he was doing his work as a blacksmith without any inconvenience or sign of return.

Remarks by Mr. ROBINSON.—This case is a further proof that the chances of obtaining a successful result after resection of the bowel are considerably increased by performing a secondary operation for uniting the ends. Here there was the additional advantage that the large bowel from its inactivity had diminished in calibre, thus permitting more perfect union of the ends. Although Senn's indiarubber tube was tried for the approximation, its sole use proved inefficient for perfect junction, as it would collapse, and it was necessary to have resort to Lembert's method of suturing. In spite of this, the gut unfortunately gave way, but luckily the escape was from the wound. The fistula remaining behind was ultimately closed by a plastic operation in which the whole thickness of the skin was raised, allowed to thicken, and then transplanted.

ROYAL ALBERT HOSPITAL, DEVONPORT.

A CASE OF FOREIGN BODY IN THE BLADDER AND URETHRA.

(Under the care of Mr. J. HARLEY GOUGH.)

IN THE LANCET of Nov. 7th, 1891, p. 1039, Mr. Selby W. Plummer records a case of foreign body in the bladder and urethra, which was treated at the Durham County Hospital. A somewhat similar case occurred recently at the Royal Albert Hospital, Devonport. In both instances the foreign body, a long bonnet pin, was successfully extracted by perineal section. In our remarks we referred to cases[1] of similar injury in which it was found possible to remove the foreign body after manipulation; the point, being made to project in the perineum, was pulled out until the head prevented further progress, then turned, the head pushed forwards through the meatus, and the pin extracted.

J. T——, aged fifty-one, a big, fine-looking man, came to the out-patient department on the afternoon of Oct. 5th, 1891. He said that the night before, when under the influence of drink, and for reasons he would not explain, he passed a long bonnet-pin head first down his "pipe" and could not get it out. Owing to some feeling of discomfort and pain after micturition he sought relief at the hospital. On examination nothing could be felt in the penis, but deep in the perineum a prominent point could be made out. The scrotum was pulled up, and without an anæsthetic an incision was made over it, and the point of the pin exposed. This was seized with a pair of Spencer Wells' pressure forceps and forcibly drawn forwards till the beaded end was held by the urethra. The urethra was incised and the pin extracted. A No. 10 gum elastic catheter was passed down the urethra into the bladder and tied in, and the patient put to bed. Two days later the catheter was replaced by another. On the fourth day the wound in the perineum had healed by first intention, and on Oct. 10th, 1891, the patient was discharged cured. The pin was an ordinary blue bonnet one, five inches long, with a black-beaded head.

[1] Brunel: THE LANCET, vol. i. 1887, p. 470; also case under Messrs. Hunter and Curtis.

Medical Societies.

PATHOLOGICAL SOCIETY OF LONDON.

Enchondroma following upon Multiple Exostoses.—Dermoid Cyst attached to Omentum.—On Suppuration.—Rupture of Spermatic Vein simulating Melanotic Sarcoma.—Congenital Malformation of Heart.—Carcinomatous and Adenomatous Mammary Growths.—Mucous Cysts of Ureters.

AN ordinary meeting of this Society was held on Feb. 2nd, the President, Sir George Humphry, in the chair.

Dr. GRIFFITHS of Cambridge brought forward a specimen of Enchondroma following upon Hereditary Multiple Exostoses. He showed the bones of the left lower limb of a man aged thirty-one, on which there were many exostoses of the usual kind, and one large enchondroma on the upper end of the tibia. The enchondroma had taken a rapid growth for nearly a year, and latterly had given rise to pain and much inconvenience from its bulk. There were other exostoses on the right lower limb, but there were none on the trunk and upper limbs, where the only detectable change was thickening and nodulation at the epiphysial lines of the lower end of the radii, upper end of the humeri, and inner ends of the clavicles. The affection ran in his father's family—one brother had "lumps" and a deformed arm; another brother and two sisters, who took after their mother's family, remained quite free. The father had many lumps, on the lower limbs especially; also his grandfather, who died from the enlargement of one of the lumps, and a paternal aunt, who had lumps and a deformed arm. Dr. Griffiths then referred to similar published cases, and expressed his opinion that it was as yet difficult to determine the real etiology of these growths.—The PRESIDENT remarked that the patient exhibited a combination of two kinds of cartilage growth. There was a chondro-exostosis of usual characters, but remarkably multiple and hereditary. This was associated with a cartilage growth, which had no bone formation at all; it encircled the bone as fibromas often did, and did not spring from a single point. These chondromata were not commonly hereditary. This patient thus showed both chondro-exostosis and subperiosteal chondroma, but he presented no instances of the true enchondroma of the phalanges. It was interesting to note that there was a condition present which seemed to be some approach to rickets, but there was nothing to explain the ankylosis of the tibia and fibula at their lower ends.

Dr. GRIFFITHS also exhibited a Dermoid Cyst which was attached to the lower and free border of the omentum. He regarded this as probably having had origin in one or other ovary, become pedunculated and attached to the omentum, and then ultimately it became severed from its original connexion.—The PRESIDENT said that the tumour gave way during the operation, and the contained fatty material flooded the peritoneum. It had only increased in size of late, though probably it was of congenital origin. Though these tumours were occasionally found in the peritoneum, it was difficult to believe that they were formed in connexion with the ovary. He referred to a case in which hair, teeth, &c., had been found in a woman's bladder; he removed them successfully, but he could not conceive how they had got there. He believed that these tumours occurred only in women, and if that were the case it was in favour of their ovarian origin.—Mr. W. G. SPENCER asked

if it were necessary, in order to account for these dermoid cysts, to believe that they were developed from epiblast invaginated from the surface. The epithelium of the ovary and also that of the Wooffian body and its duct was of cœlomic origin, and therefore mesoblastic, though of course it must have been primarily derived from either the epiblast or the hypoblast. If dermoids could thus arise from cœlomic epithelium, it was quite possible for them to spring from the omentum direct, the covering of that structure being of similar origin.—Mr. SUTTON said that dermoids inside the peritoneal cavity only occurred in women. They had been seen in the pelvis in both men and women, but they were always beneath the peritoneum. Dermoids of the omentum had been, so to speak, "caught in the act" of shifting their habitation from the ovary to the omentum, and had been found with a slender attachment to the ovary and a firm adhesion to the omentum by Knowsley Thornton, Doran, and himself. Non-dermoid tumours had also been seen shifting their position from the ovary to the omentum. These facts were more convincing than arguments founded on strange fancies as to the origin of epithelium. He asked the President if the ovaries and tubes of this case were examined at the time of the operation.—Dr. GASTER referred to the case of a female child aged eight, who was operated on at the Children's Hospital at Bucharest by Dr. Rominceano. There had been for some time a fistula in the right iliac region, and on abdominal section a dermoid cyst of the size of a large orange was found in the peritoneum, in the right side; it was safely removed. The child died two days after the operation, and at the necropsy, which was carefully performed, the ovaries were found quite normal.—Dr. GRIFFITHS, in reply, said that the tumour was attached to the under-surface of the omentum, and did not appear to be formed in its substance.

Mr. S. G. SHATTOCK read a paper on the inadequacy of the current terms applied to Suppuration, with a note on Peptone in Pus. The author contended that the time had arrived for a revision of the terms at present in use as applied to suppuration. The terms "suppuration" and "pus" were purely anatomical, and included things quite different in their etiology. Setting aside larger questions, the process of acute suppuration could etiologically be distinguished from other forms, and that it was as specific in nature as tuberculosis or syphilis was now well established by experiment. Koch's four postulates in this case were all capable of fulfilment, whilst the doctrine was confirmed by the check experiments of introducing aseptic chemical irritants beneath the skin of animals, and which, if the animals were healthy, produced inflammation but not suppuration. A strict parallel might be drawn between tuberculosis in its different manifestations and acute suppuration. Corresponding with the localised tubercular lesion was acute abscess; "diffuse suppuration" represented the results of local infection when the tissue elements failed to cope with the virus. The secondary glandular infection in tuberculosis and the glandular abscess common after suppuration at a distance were parallel, whilst pyæmia was the counterpart of generalised tuberculosis. To bring out the facts, the term "pyosis" was suggested by the author; generalised pyosis would be what is termed pyæmia, glandular pyosis the secondary glandular infection, whilst the acute abscess or acute suppuration of a wound would be pyosis in a local form. The author afterwards recounted some observations on the presence of peptone in the pus of acute abscesses. He had examined thirty cases. The simplest method of showing this was to shake the pus with half its bulk or less of saturated solution of ammonium sulphate and then add crystals of the same salt to saturation; then filter. If a drop of copper sulphate solution be added to the clear filtrate no precipitate is produced, for the ammonium sulphate precipitates all the proteids except peptone; and on adding excess of solution of caustic potash a dense white precipitate of potassium sulphate is thrown down. On this subsiding the pink colouration of the clear supernatant fluid, though usually pale, shows the presence of peptone. He had been able by dialysing pus to show the same. The peptone, of all the proteids, alone passes through the dialyser, and may be shown in the water by the biuret reaction, sulphate of copper solution, and solution of caustic potash. For the separation of the albumoses Sydney Martin's method was necessary, and if properly carried out the demonstration was easy; the pus was shaken with excess of alcohol, and kept several weeks in a stoppered bottle, filtered, the residue on the filter dried and rubbed up with distilled water and filtered. Albumoses and peptone were alone dissolved. The addition of ammonium sulphate to the filtrate produced a precipitate of albumose, and the filtrate from the latter gave the biuret reaction of peptone. The presence of albumose and peptone in pus was not peculiar to the action of pyogenic microbes. Martin had shown both in the alkali albumen in which he had grown bacillus anthracis.—Dr. HUNTER said that undoubtedly the peptone was formed by the agency of the organisms in the pus, and it was possible to give even a clearer demonstration of this fact; for if the ferments were isolated from the organisms they would still form peptones in albuminous fluids. This explained the reason of localised or diffuse inflammation occurring after primary infection. If the organism were one which gave rise to a ferment of great peptonising power, then the tissues would undergo rapid solution, and the lymphatics being quickly blocked the inflammation would remain localised; but if, on the other hand, the organism produced a ferment of low peptonising power there was but little solution of tissue, the lymphatics remained open, and the inflammation spread.—Dr. LEE DICKINSON said that he had examined several specimens of pus from pleural empyemata, and had always found the albumose to be more abundant than the peptone; but this might be possibly because the peptone was rapidly absorbed from the pleura. Dr. Martin had found very little peptone in the fluid in which anthrax bacilli had been cultivated.—Mr. SHATTOCK, in reply, said that the amount of peptone in all his specimens was very small, being indeed a mere trace, and the amount of albumose was much larger.

Mr. W. G. SPENCER exhibited the Right Testis and Spermatic cord of an Infant, the epididymis and lower part of the cord having been surrounded by, and infiltrated with, blood-clot. Microscopic specimens showed, in addition, large spermatic veins in the midst of the mass. It was taken from a child fourteen days old, who was brought to the Westminster Hospital with a tumour in the right scrotum. The affection had been noticed three days after, but the mother could not say whether it was present at birth. The birth was normal, and there were no other indications of injury or of disease. The swelling involved chiefly the back of the testis and the lower part of the cord. The skin over the swelling was adherent, and bluish-black in colour. Beyond the swelling the skin was normal, without sign of bruising or of inflammation. On puncture it proved to be solid in consistence, some blackish fluid escaping. Mr. Macnamara saw the case, and it was agreed that the disease appeared suspiciously like a melanotic sarcoma. On incision the surface of the section looked black; the testis and the cavity of the tunica vaginalis were healthy, and there was no sign of blood-clot in a cavity. The diagnosis of melanotic tumour seemed correct, and castration was performed, which was followed by rapid healing. But on microscopic examination by Dr. Hebb, the tumour was found to have been due to an infiltration of the epididymis and cord by extravasated blood. Concerning the exciting cause of this condition he had no evidence. Light was thrown upon the predisposing conditions by a paper of his on the Origin of Varicocele in vol. xl. of the Society's Transactions. In it he described the large size of the veins, which, at first belonging to the more vascular Wolffian body, were transferred later on to the less vascular testis. The veins accordingly tended to become relatively less in size and number by a process of atrophy, which affected the right more than the left side. But these veins were still relatively large and numerous at birth, as could be seen in the drawings attached to the paper referred to as well as in the microscopic specimens shown.—Dr. HERBERT SPENCER remarked that hæmorrhages in the testes and spermatic cord were not at all uncommon in stillborn children, especially in those in whom there had been breech presentation. Hæmorrhages were also not uncommon in other viscera. He had brought forward the results of over 300 post-mortem examinations in a paper which was read before the Obstetrical Society, and in which he had referred to the hæmorrhages into various organs. Important points in connexion with the hæmorrhages were the question of future impotence and of the prevention of the descent of the organ in cases of undescended testis.—Mr. W. G. SPENCER replied that although aware of hæmorrhages in these regions in breech presentations, in the case under discussion the tumour was so hard and firm that it was believed to be of malignant nature, and hence the castration.

Dr. NORMAN MOORE showed a Congenital Malformation

of Heart from a boy aged five months, who had been under observation since three weeks of age. The aortic arch was large, and arose from an abnormally large left ventricle. A mitral valve opened into this from a left auricle of about normal size. The foramen ovale was widely open, and the right auricle was of double the normal capacity and thickness. There was no actual tricuspid valve, but only an opening the size of a pin, which led into a right ventricle not larger than two pins' heads. From this issued a very minute pulmonary artery without valves at its orifice. This doubled in width near the ductus arteriosus, which was patent. The circulation was carried on by the single ventricle, the pulmonary blood stream being directed through the ductus arteriosus from the aorta. The blood from the hypertrophied right auricle was driven into the left auricle, and thence through the wide mitral valve into the left ventricle. The blood currents were all of them mixed. The child was deeply cyanosed, but had no clubbing of its fingers or toes. It was always very short of breath and never sucked well. A first and second heart sound were audible, but no murmur.

Mr. G. B. M. WHITE showed a Mamma containing Adenomatous and Carcinomatous Tumours from an unmarried woman aged sixty-one. A tumour had been noticed in the right breast for about two years. After removal, besides the carcinoma, two adenomata were found in the same breast lying close to and beneath the main tumour. At the same time a small adenoma was removed from the left breast.

Mr. J. JACKSON CLARKE showed the Kidneys, Ureters, and Bladder of an old woman who was moribund when admitted into St. Mary's Hospital under Dr. Lees. A large hæmorrhage in the right cerebral hemisphere was found. The arteries at the base of the brain were extremely atheromatous. Her history could not be obtained. The left kidney was hydronephrotic. There were a few small cysts placed close together in one of the pyramids. There were cysts in a dilated calyx and in the pelvis, and very numerous cysts of the average size and the colour of hemp-seed in the upper half of the ureter. The right kidney contained one subcapsular cyst; the right ureter was normal. In the bladder there were cysts at the ureteral orifices and at the neck. The cysts in the ureters contained the large cells, which have been supposed to be coccidia. Mr. Clarke's sections showed all stages of development of the ureteral cyst, of which the smallest contained detached epithelial cells, only slightly œdematous. Mr. Clarke regarded the larger cells found in the older cysts to be likewise epithelial cells, which had undergone further degeneration. There were none of the large cells in the cyst of the kidney and of the bladder. Mr. Clarke thought that possibly some of the cases of hydronephrosis which had been cured by massage might have been due to ureteral cyst, which easily collapsed. He thought a more general use of the cystoscope might lead to the recognition of similar conditions during life, and that then examination of the urine might reveal some chemical irritant as the cause of the condition.—Mr. BLAND SUTTON referred to Mr. Silcock's case, in which the cells had continued to grow after the tissue had been placed in a hardening solution of weak chromic acid. It was impossible to conceive of tissue cells doing so, though quite conceivable of psorosperms.—Mr. GRIFFITHS asked Mr. Clarke whether he knew if cysts of any size could arise from cystic degeneration of a single cell.—Mr. CLARKE replied in the negative, and expressed himself as still unconvinced, so far as his own specimen was concerned, that the cysts in question were due to the presence of parasitic psorosperms.

The following card specimen was shown:—Mr. J. J. CLARKE: Fibroma of Small Omentum.

OPHTHALMOLOGICAL SOCIETY.

Tuberculosis of the Iris, Suspensory Ligament, and Retina.—Etiology, Prognosis, and Treatment of disseminated Dot Cataract.

AN ordinary meeting of the Society was held on Thursday, Jan. 28th, Mr. Henry Power, F.R.C.S., President, in the chair.

Mr. R. L. KNAGGS (Leeds) communicated a paper on a case of Tuberculosis of the Iris, Suspensory Ligament, and Retina, which was read by the secretary. The patient, a boy aged nine months, had iritis of a quiet type associated with fourteen to twenty white nodules in the iris. Those in the lowest part of the anterior chamber grew most rapidly and coalesced, forming a large yellowish mass, which produced a considerable growth at the sclero-corneal margin. The eye was excised, but the child died seven weeks later from tubercular meningitis. Sections of the eye showed that the iris had been transformed into a tuberculous mass, in which were many distinct miliary granules. The growth had bulged and thinned the outer tunic of the eye, had penetrated the uveal pigment layer at a point just in front of the ciliary body, had passed through the suspensory ligament, and had been stopped abruptly at the hyaloid. The canal of Petit was filled with inflammatory exudation, and contained several tubercles in which giant cells were well marked. The disposition of the suspensory ligament did not seem to have been altered by the tissue in which it was embedded. In the lens were cell spaces filled with inflammatory cells, and in the retina there was an inflammatory focus situated between the nerve fibre layer and the pigment layer, the latter being quite unaffected. The case was recorded not only as a contribution to the literature of tubercular iritis, but because of the bearing it had upon questions connected with the suspensory ligament. Drawings of the pathological conditions were exhibited.

Mr. CHARLES WRAY (Croydon) read a paper on the Etiology, Prognosis, and Treatment of disseminated Dot Cataract. After commenting on the narrow limits of the literature of the subject, he pointed out that the commonest form of this affection was characterised by the presence of large numbers of very thin, punctiform opacities, generally less than ·5 millimetre in diameter, symmetrically arranged in the substance of the lenses. The opacities were, as a rule, most numerous towards the equator of the lens, and were at times quite absent from the periaxial parts. Sometimes, in addition to the dots, there were streaks of opacity arranged without reference to the anatomical structure of the lens; occasionally the dots were so minute, and situated so peripherally, as to be overlooked unless very carefully searched for. The following varieties of dot cataract had been noticed:—(1) The simple form, as above described, occurring in young subjects, with no other changes suggestive of lens degeneration; (2) the simple form, complicated by the presence of opaque streaks arranged without reference to the anatomy of the lens; (3) the last mentioned further complicated by the presence of vacuoles; (4) the above conditions with degenerative changes suggesting ordinary advancing cataract. The affection was most easily recognised in childhood; in later life it might be mistaken for developing senile cataract. Nothing in the history or condition of the patients seemed to account for the lens changes; the simplest view was that they were merely transmitted structural peculiarities, like the white dots found on the finger nails. This simple explanation seemed the more probable, since in each case in which the condition was found in the offspring it was observed in the mother. In regard to prognosis, two points were noteworthy—the non-deterioration of vision in the parents, and the presence of the dots unchanged in one patient who had advanced nuclear (senile) cataract. In only one instance had the question of treatment to be seriously discussed, and in this, the vision with correcting glasses being equal to the patient's requirements, no active interference was advised. If in any case the sight were not sufficient for the requirements of the individual, the rules applicable in the treatment of lamellar cataract would apply. Nine cases were recorded, nearly all of which were complicated with ametropia. In six cases, in which the children were discovered to have disseminated dot cataract, the same condition was found in the mother. In no case in which it was present in the child was it absent in the parent. In two cases it was present in the parent—once the father, once the mother,—but absent in the offspring.—Mr. SYDNEY STEPHENSON said he had seen a number of cases like those described by Mr. Wray, and in several he had noted congenital defects of the eyes—for example, opaque nerve fibres, persistent pupillary membrane, &c. He asked if Mr. Wray had found such defects in his cases.—Mr. LANG said that, in his experience, the lens was easily extracted in cases of dotted cataract with nearly clear cortex, and he had consequently no hesitation in advising operation.—Mr. LAWFORD thought the vacuoles in the lenses alluded to by Mr. Wray were not uncommon in cases in which no other evidence of lenticular change was forthcoming. He had observed some

cases for three or four years, and had been unable to detect any increase in size or number of the vacuoles. He asked whether their presence had any significance.—Mr. DOYNE was unable to agree with Mr. Lang as to the ease with which these dotted cataracts could be extracted. He had found considerable difficulty in removing the cortical portion of the lens.—Mr. GUNN inquired if the dots of opacity were very numerous, and Mr. Juler inquired if the condition was not generally progressive.—Mr. WRAY, in reply, said that the dots in the lens were generally present in large numbers. He thought that the opacities in most cases remained nearly stationary. He had seen one case in which there was a persistent hyaloid artery.

The following cases and card specimens were shown:—

Mr. CRITCHETT: A case of Conical Cornea, treated by Galvano-cautery without Perforation.

Mr. GUNN: Apparatus for Illuminating the Eyeball from behind.

Mr. JULER: Microscopic Demonstration of Hyaloid Growth from the Lamina Vitrea of the Choroid.

Mr. HIGGENS: Tuberculosis of Iris.

Mr. ERNEST CLARKE: Case of Unusual Retinal Detachment (?) Neoplasm.

SHEFFIELD MEDICO-CHIRURGICAL SOCIETY.

THURSDAY, JAN. 14TH.

Mr. W. DALE JAMES, M.R.C.S., in the chair.

Gastric Ulcer.—Dr. GORDON related a case of Gastric Ulcer with Gastro-colic Sinus, and showed the specimen. A young woman came under his treatment for vomiting. She had always been subject to constipation, and three years previously had been attacked with sickness and vomiting, which continued more or less frequently until she came under his notice. Rest in bed and bismuth and soda mixture relieved the sickness completely for six weeks, but it eventually returned without any apparent cause. The vomited matter then became stercoraceous, but on no occasion did any undigested food appear in the motions. The case was then supposed to be one of chronic constipation with the large bowel lined with fæces. Enemata were ordered, but on the fourteenth morning the patient vomited a pint injection of soap-and-water ten minutes after it had been administered. From this time she gradually sank, and died from exhaustion. At the necropsy, only sufficient peritonitis was found to unite the peritoneal surface of the stomach to the transverse colon at the seat of the ulcer, thus preventing the gastric contents from passing into the peritoneal cavity, when perforation took place through the sloughing of the base of the ulcer. The communication between the stomach and colon was circular in shape, three-quarters of an inch in diameter, and situated on the posterior surface of the stomach two inches from the pylorus. There was an absence of lienteric stools throughout the whole progress of the case.

Dr. SOMERVILLE showed four pairs of Lungs presenting the character of Fibroid Tuberculosis, which had been taken from men engaged in "dry grinding." After reading brief clinical notes of the cases, he drew attention to the following points: (1) The pleural thickenings; (2) the tubercles, which were pigmented and of large size, being from one-eighth of an inch to half an inch in diameter, and so closely arranged in some parts as to give the lung a very dense feeling; (3) the cavities which lay between fixed points, and had smooth walls; (4) the bronchial glands; and (5) the microscopic appearances. Dr. Somerville also remarked on the pathology of this form of phthisis.

Treatment of Phthisis.—Dr. HUNT read a paper on the Treatment of Phthisis. He gave his experience of various modes of treatment during the past ten years, which had led him to place little reliance on the use of drugs except for the purpose of relieving distressing symptoms. He pointed out that the only hope of successfully curing phthisis must depend on being able to attack the disease at its seat of origin. This mode of treatment had a sound pathological basis, and all the latest experiments encouraged perseverance in this direction. The results, in a great number of cases treated by antiseptic injections into the lungs through the larynx, were related by Dr. Hunt, who said that the good obtained by residence in high altitudes was due to the antiseptic influence of the atmosphere, and concluded by referring to the successful results obtained in the case of several of his own patients who had been sent to Davos Platz.

THURSDAY, JANUARY 28TH.

Dr. MARTIN in the chair.

Mr. R. FAVELL showed a specimen of Hæmato-salpinx removed from a woman thirty-four years of age. The tube was distended to about the size of a small orange, and was filled with blood-clot. From examination there was apparently no evidence of the tube being gravid. Mr. Bland Sutton had kindly examined the specimen, and his opinion was that it was a case of true hæmato-salpinx.

Malignant Disease of the Mesentery.—Dr. KERR showed specimens from a case of this kind. The patient, a man aged thirty-three, had been under Dr. Dyson's care in the infirmary. There was a seven months' history of abdominal pain, especially towards the left side, aggravated by food, with loss of flesh, and latterly some sickness. The patient had been a hard drinker. On examining the abdomen a tumour was felt in the left hypochondrium, projecting beneath the costal margin and extending into the left lumbar region. The growth was movable, had a rounded end, and could be tilted from behind. There was some tenderness over the tumour, and more still over the umbilical region where the tumour was not felt. The tumour simulated an enlarged spleen. The blood when examined was found normal. The tumour increased very rapidly in size after admission, enlarging towards the epigastrium, and becoming softer, semi-elastic, and very tender. The patient died within two months of admission into the infirmary. Post-mortem examination disclosed a large mass of new growth occupying a great part of the abdomen, especially the left hypochondrium, protruding below the ribs and extending up in front of the spleen, which was small but healthy. The mass was soft and pulpy, nodulated, and firmly adherent to the stomach. The liver was enlarged, and infiltrated with new growth. Microscopically the growth showed alveoli of delicate connective tissue filled with masses of round cells, which were granular and had well-marked nuclei—doubtless encephaloid cancer.

Ulcerative Colitis.—Dr. DYSON read a paper on Ulcerative Colitis. He related a case and showed the colon of the patient, who died in the infirmary while under his care. The patient was a man aged thirty-nine, a traveller. He had been in the Horse Guards, but had never been abroad. There was no history of syphilis, alcoholism, or dysentery. The cause of the disease was not clear. The patient was very sallow, cachectic, and emaciated. He was very severely ill for two months. He suffered from severe and uncontrollable diarrhœa, the motions generally being fluid, ochre-coloured, offensive, and latterly containing blood. There was occasional pyrexia, but the temperature for the most part was normal or subnormal. There was no pus or mucus seen in the motions. The patient died of asthenia. Remedies, consisting principally of opium and astringents, were of no permanent effect. Dr. Dyson referred to the cases reported by Dr. Hale White. The prognosis was almost always bad. Post-mortem examination in Dr. Dyson's case showed severe colitis with ulceration, extending from the middle of the transverse colon to two inches above the rectum. The ulcers were numberless, some well defined, some extending deep down to the peritoneal coat, many of them coalescing, leaving prominent islets of uninvolved mucous membrane between. Dr. Dyson also related a case of follicular ulceration of the colon, laying stress on the great importance of distinguishing between these two varieties of ulceration and also on the importance of not confounding them with severe colonic catarrh with the presence of casts in the motions.

MIDLAND MEDICAL SOCIETY.

WEDNESDAY, NOV. 25TH, 1891.

Mr. BENNETT MAY, F.R.C.S., President, in the chair.

Molluscum Fibrosum.—Dr. SUCKLING showed a woman aged seventy who was covered with fibrous tumours varying in size, some pendulous, some sessile. The growths commenced thirty years ago, and fresh ones had continually appeared since. There was no hereditary history, and no

cause for the disease could be elicited. None of the growths had ever disappeared spontaneously. A few of the growths had a comedo on the summit, and there was a large one growing from the mucous membrane of the hard palate. Some of the tumours were lobulated. The disease could be easily distinguished from multiple neuromata, lipomata, and from molluscum contagiosum.

Mr. JORDAN LLOYD showed a patient forty years of age upon whom he had performed the operation of Kolpohysterectomy for uterine cancer in May last. The tumour was epitheliomatous, affected the whole of the cervix, and had existed for six months. The operation was performed in the usual manner, the left broad ligament being clamped and the right one ligatured. Recovery was uninterrupted. She had gained more than a stone in weight, and her skin had become ruddy and firm again since the operation. She was free from pains, and able to do her housework as well as ever. Mr. Jordan Lloyd also showed a large Myxomatous Tumour removed from the right popliteal space of a woman about sixty-five years old. The whole of the structures of the space were spread about the growth, which weighed three pounds after removal, and had been slowly growing for nearly twenty-five years. Of late, however, it had increased with great rapidity. The patient was making a good recovery.

Dr. MALINS showed a Fibro-cystic Tumour of the Uterus. The patient was forty-one years of age; no family or miscarriages. She complained of pain in the left side of the chest. A tumour was found in the right side of the abdomen, thought to be ovarian. It was attached by a pedicle one inch wide to the right side of the uterine fundus; it was filled with about two pints of clear fluid, and its interior was degenerating—i.e., breaking up. The pelvis was washed out with water, a glass drainage-tube being kept in for thirty-six hours. The patient left the hospital quite well on the twenty-fifth day. Dr. Malins also showed a Polypus. The patient was forty-four years of age; two children; married twenty-seven years; history of menorrhagia for four years. The patient was blanched and anæmic, and she had never been examined until just before admission. The polypus was excised on Nov. 17th. The patient has done very well since.

Calculus impacted in Ureter forming Sub-vaginal Tumour.—Mr. JOHN W. TAYLOR narrated two recent cases of calculus impacted in the ureter which he had diagnosed from the presence of a little painful tumour felt on vaginal examination in the situation of one ureter near its entrance into the bladder. In one of the cases the stone had passed, with disappearance of the local tumour. In the other case the tumour persists.

Dr. STACEY WILSON showed a very typical specimen of Pemphigus.—Mr. HALL EDWARDS read a paper on the Optical Lantern as an Instrument of Medical Education. A number of slides of diagrams, cases, micro-photographs, and pathological specimens were exhibited on the screen.

BRADFORD MEDICO-CHIRURGICAL SOCIETY.

TUESDAY, DEC. 15TH, 1891.

J. H. BELL, M.D., in the chair.

Acromegaly.—Mr. APPLEYARD showed a woman aged forty-three, in whom, since twenty, there had been persistent amenorrhœa. The relatives had noticed no particular change in her features or voice. Ten years ago her hands and feet were noted as increasing in size. Half-a-dozen years ago a curvature forwards of the upper part of the spinal column began to show itself. The voice was deep, forehead retreating, orbital and malar ridges well developed, lower jaw natural size, the bones and areolar tissue of hands and feet uniformly enlarged, the skin soft and thickened. Some years ago she frequently noticed outbursts of sweating in hands and feet, not so evident now. When the hands are extended the metacarpo-phalangeal joints are over-extended, the terminal phalanges being slightly flexed. Both the clavicles and first ribs on each side are considerably enlarged. The mucous membrane of the mouth is more succulent than natural, and the lower lip markedly everted. Reflexes and special senses normal. No alteration of fields of vision, no headache, vomiting, or evidence of intra-cranial tumour, no albuminuria or glycosuria, no signs of tubercle in lungs, but difficulty of respiration; bronchial catarrh, for which she is under treatment; the mental state a little inert; great muscular weakness. When first seen, two months ago, could not walk across a room.

Lupus inert to Tuberculin.—Dr. BELL showed a case of lupus under observation for very many years, which had been treated for twelve months past with tuberculin; improvement had resulted, but the disease was there still, and maximal doses corresponding to one cubic centimetre of undiluted tuberculin now had no effect on either patient or disease.

Sarcoma of Femur.—Mr. APPLEYARD showed a specimen om a case of accident; femur fractured whilst walking in the street. As union did not take place, and callus was suspicious, it was cut down on and found to be a rapidly growing sarcoma.

Other Cases &c.—Dr. S. LODGE: Bilateral Palsy of Laryngeal Abductors, improving under Iodides. Mr. WILMOT: Lupus Erythematosus in a Child. Mr. HORROCKS: Chronic Hydrocephalus with Meningocele treated by operation. Mr. PETTITT: Enlarged Dislocated Spleen in Infant. Dr. ADOLPH BRONNER: Cases of Atrophic Rhinitis of fetid and non-fetid nature, and a case of Peculiar Laryngeal Growth. Dr. RABAGLIATI: Sarcoma of Kidney; Nephrectomy. Mr. HORROCKS: Scirrhous Mammæ, with Organised Blood-clot. Mr. APPLEYARD: Peculiar Skin Disease allied to Molluscum Contagiosum.

Reviews and Notices of Books.

A Clinical Text-book of Medical Diagnosis for Physicians and Students. By OSWALD VIERORDT, M.D., Professor of Medicine at the University of Heidelberg. Authorised Translation by FRANCIS H. STUART, A.M., M.D. (New York). Edinburgh and London: Young J. Pentland. 1891.

THE somewhat extensive series of text-books dealing with the methods of physical diagnosis which within the last decade have been placed at the disposal of the English reader has been certainly enriched by the addition of Prof. Oswald Vierordt's work, for the translation of which the profession is indebted to Dr. Stuart. The subject is one which is not capable of great variety in the manner of its presentation, but very much indeed depends upon the author's exposition of it and his appreciation of the relative importance of the facts he describes. It is of great advantage to the learner, moreover, to meet with a writer on the subject whose position as physician and professor enables him to speak from the fulness of personal experience, and who knows also the best method of systematising his material in order that it may be of the greatest service. The methods and instrumental aids to diagnosis have now become so numerous that it is no light task for a physician to describe them fully and satisfactorily; and even in the present volume, which in its exhaustive character equals any that has hitherto appeared, it has been deemed fitting to relegate to an appendix the subjects of laryngoscopy and ophthalmoscopy, the full treatment of which would have necessitated a great increase in the bulk of the work.

The plan on which the book is arranged is that usually adopted in works of this class, for indeed it is the natural method of the systematic treatment of the subject. First, the results of general observation and examination of the patient, his nutrition, the state of the skin and subcutaneous tissues, and the temperature of the body. There is no material point left untouched by the writer in this section, and opportunity is taken now and then of entering more fully than usual into pathological questions; as, for instance, when speaking of jaundice, the suggestion is made that in many cases of so-called hæmatogenous jaundice, associated with hæmoglobinæmia—i.e., destruction of red corpuscles,—the bile may be so thick and concentrated as not to flow through the duct. At the same time, it is not disputed that hæmatoidin (or bilirubin) may be formed from

the hæmoglobin set free in the bloodvessels, thus constituting a true blood-jaundice. In describing the precautions needful for the accurate observation of the temperature of the body, Professor Vierordt emphatically recommends that the temperature should not be taken in the mouth; but we are of opinion that when due care is observed to place the bulb of the thermometer beneath the tongue there is not much risk of fallacious results.

The next section deals with the Examination of the Respiratory Apparatus, and contains many valuable hints as to the practice of percussion and auscultation. The interpretation of the results of percussion, according to the physical conditions of the parietes, is assisted by a series of novel and accurate diagrams. The author is no advocate for the use of the binaural stethoscope; and herein we agree with him, at least in part, for we deem it unwise of the student to cultivate the use of this instrument to the exclusion of obtaining familiarity with the rigid stethoscope. Professor Vierordt wisely refrains from any detailed discussion upon the causation of the vesicular murmur, and contents himself with expressing his belief that "vesicular breathing" is merely the bronchial breath sound formed at the rima glottidis and altered by being prolonged into the air-containing lung. It certainly conduces to clearness to start with the conception of vesicular and bronchial breathing as the root sounds (if we may so express it) of all the variations in the respiratory murmur that appear in various conditions of disease. We confess to a slight disappointment in finding that one so versed in auscultation and its meaning should have retained the word "râle" to comprise the "dry" rhonchal as well as the "moist" crepitant adventitious sounds. To be sure there is high authority for this, but the misuse of the terms is liable to be confusing to the tyro. There is an ample discussion upon the characters of expectoration and its microscopical investigation.

In the following section, that of the Examination of the Circulatory Apparatus, the reader will find a clear and sensible description of cardiac signs and murmurs, and an adequate description of the pulse and of the changes met with in the blood. It will be seen, too, that the author holds that the murmur distinctive of mitral stenosis is diastolic or presystolic, as tested by the carotid pulse; but we find no mention of visibility of the auricular impulse in this affection (page 203). He points out that systolic retraction, limited to the apex beat, is of no significance, whereas a similar phenomenon visible over several interspaces is distinctive of adherent pericardium. Respecting the area of cardiac dulness and the variations assigned to it, he wisely recalls the fact that the precise limits vary with the individual observer. He does not attempt to explain the causation of anæmic murmurs.

The section dealing with the Digestive System necessarily contains an account of the various plans, none of which have gained much footing in this country, of the examination of the gastric secretion, both as to its capability of digesting food and of its relative contents in hydrochloric and lactic acids. The inadequacy of many of the tests devised for this purpose is pointed out. The details of examination of the various abdominal organs and the investigation of the excreta are well and amply discussed. The same may be said of the section devoted to the examination of the Kidneys and the Urine, although we miss any reference to the remarkable reaction discovered by Ehrlich in certain febrile states. But perhaps the most fully developed section is that which deals with the Nervous System, and we commend this for careful study as being a valuabe systematic exposition of a difficult subject. It is thorough and exact, reflecting great credit on the author, who indeed has rendered no mean service to medicine in having prepared a work which will prove as useful to the teacher as to the student and practitioner. The translation is on the whole excellent; now and then the reader meets with novel phrases and crudities of expression, and there is an occasional lapse in the spelling of proper names, as "Veil" for Weil (pp. 103 and 108), "Scoda" for Skoda (p. 109), "Gabett" for Gabbett (p. 187), "Bamber" for Bamberger (p. 190), "Neiser" for Neisser (p. 427), and "Gmellin" for Gmelin (p. 492), but these are only venial faults, and are well atoned for by the general excellence of the work, its admirable index, and elegant production.

A Manual of Practical Hygiene. By the late EDMUND A. PARKES, M.D., F.R.S., Professor of Military Hygiene in the Army Medical School. Edited by J. LANE NOTTER, M.A., M.D, F.C.S., Professor of Military Hygiene at the Army Medical School, Netley. Eighth Edition. London: J. & A. Churchill. 1891.

FROM the time that the late Professor Parkes first published his manual of Practical Hygiene up to the present day it has occupied the foremost position among works of the kind. It was what may be termed an epoch-making book, and its intrinsic merits were at once recognised. After Dr. Parkes' death in 1876, the late Professor De Chaumont continued to edit the new editions called for from time to time, and now the eighth edition has been brought out by the present Professor of Hygiene at the Army Medical School, Dr. J. Lane Notter. In the case of a book of 769 pages, and supplied with copious references and foot-notes, it would be impossible within reasonable limits to afford anything like an adequate idea of its scope, method of treatment, and the alterations and additions that have been made since the publication of the last edition. And, happily, it is unnecessary; for when a work has attained the popularity of "Parkes' Hygiene," little, if anything, remains to be said about it by the reviewer. Its success speaks for it. The book has been a more fruitful source of good to the soldier and the State than can be easily realised. It is full of instruction for the medical officer and, indeed, for all who have anything to do with questions of hygiene and public health. Professor Notter tells us in his preface that when Dr. de Chaumont died, in 1888, he left nothing to indicate that he contemplated any change in the general plan of the manual, consequently the same arrangement has been adhered to in the present edition. While the scope of the work remains unchanged, however, every chapter has undergone careful revision, and as far as possible been brought up to date. Indeed, there is scarcely a page in which additions or alterations do not occur. A comparison of the present with former editions, so far as we have made it, shows this to be the case. To name a very few, we may say that in Chapter I., on Soils, we trace numerous alterations and additions, especially in connexion with soil influences and temperature on disease, soils in order of healthiness, and micro-organisms in soil. There is a fresh section on the Bacteriological Examination of Water, and an important addition on Field Organisation in War. The manual is furnished with a good index.

Professor Notter thanks Mrs. Bruce for the drawings illustrating the characters of starches and bacteria, and expresses his sense of indebtedness to his friend and colleague Surgeon-Captain A. M. Davies, Assistant Professor of Military Hygiene, for his revising aid. The editing of a book of this kind involves great research and the exercise of thoughtful care and of a cultured judgment, and the eighth edition of Parkes' Practical Hygiene reflects much credit on the Army Medical School.

New Inventions.

SHOT-PROOF SPECTACLES.

THE constant recurrence of serious accidents to the eyes of gunners and others engaged in covert and various kinds of game shooting has induced Mr. Steward of the Strand to direct his attention to the manufacture of a pair of "shot-proof spectacles" which should protect the eyes of its wearer. The danger is now sadly increased by the employment of "chilled shot," which, hardened as it is, does not flatten and fall as soft shot does, but glances off in every conceivable direction after striking any hard substance. The spectacles are made to fit the eyes most accurately, and can be worn without inconvenience. Captain Willoughby Verner, of the Rifle Brigade, has recently carried out some experiments fully proving the protective power to the eyes of this new pattern of spectacles, and it was clearly shown by demonstration, after firing Nos. 5 and 6 shot at different ranges, that down to forty yards the lenses, manufactured from stout pebble or Brazilian quartz, were "shot-proof." The pellets did not in any instance penetrate the lenses, although in some cases they cracked them, whereas with glass lenses of the same thickness the glass was shivered to pieces. The spectacles weigh about one ounce, or one-third the weight of the regular commercial D eye shot-proof spectacles. The shape when finished is a well-domed oval, so as to fully protect the eyes in front and at the sides, and the front of the frame is bowed so as to preserve the proper curve. The thickness decided on is much less than in those previously introduced, and has been arrived at after several experiments to determine a reasonable minimum of substance for safety. With the sighted lenses the thinnest part is of equal thickness to the weakest part of the lenses used at trial.

THE "EUCALYPT" AUTOMATIC VAPORISER.

IT is well known that the treatment of disease by inhalation has been employed with marked benefit, but it must be admitted that the methods that have been previously adopted are not so perfect as to call for no further improvement. The "eucalypt" automatic vaporiser seems to us to fulfil two very desirable conditions which do not appear to have hitherto attracted notice—namely, that the supply of medicated vapour should be independent of any effort of the patient, and that the supply should be continuous over long periods of time. The illustration will serve to show how these ends are attained. The vaporiser consists of two upright metal bars, about two feet high, fixed opposite to one another on a firm circular wooden base, which, uniting at the top, terminate in a ring, so that the whole apparatus may be lifted and moved from one place to another. A special form of night-light rests in a socket in the centre of the base, and is covered with a glass shade. A metal pan containing a porcelain evaporating basin is suspended over the light by means of guides which slide freely up and down the upright bars. The guides are furnished with spring catches fitting into numbered notches cut into the bars, in order that the water bath with its evaporating basin may not only be brought near to or raised away from the source of heat, but may be fixed at any desired height. A thermometer is fixed in a support, which slides along one of the upright bars above the pans. The liquid to be vaporised is placed in the porcelain evaporating basin, which is immersed in water contained in the metal pan. Heat being supplied to the metal pan from the night-light, the water becomes heated and the liquid is gently vaporised. The amount of heat supplied and, therefore, of vapour given off is regulated by the height of the water bath above the night-light—the lower the water bath the greater the supply of heat, the amount diminishing progressively as the water bath is raised away from the source of heat. By means of the thermometer, which, when in use, is lowered until its bulb is covered by the liquid in the evaporating basin, the temperature at which the evaporation is going on can be at all times observed.

We find that the action of the vaporiser can be regulated with the utmost ease, and when once it is set it requires no more attention than an ordinary night-light, at the same time securing the steady diffusion of antiseptic vapours into the atmosphere. The apparatus may also be used for the vaporisation of other substances, such as thymol, lavender, terebene, phenol, iodine, and iodoform. It is the design of Dr. W. H. Spencer of Hastings, and is made by Coxeter and Son, of Grafton-street, Gower-street, W.C.

THE LANCET.

LONDON: SATURDAY, FEBRUARY 6, 1892.

IT does not appear to be probable that the judicial decision in the recent action STEELE *v.* SAVORY will affect detrimentally the ultimate settlement of the constitutional questions still awaiting solution at the Royal College of Surgeons of England. The decision may merely mean that the plaintiffs in this action proceeded upon too technical legal advice when they deliberately infringed the by-laws of the College and set at naught the authority of the Council for the purpose of testing the validity of claims which had been raised on behalf of the Members. As the matter now stands, the result of accepting the advice tendered to the plaintiffs in the action STEELE *v.* SAVORY is that the adverse decision of Mr. Justice ROMER leaves them exposed to the infliction of the penalties set forth in the broken by-law, in addition to the payment of the costs of the action. We do not for a moment believe that the Council of the College will think it advisable to act upon the powers which they possess. The plaintiffs have been judicially declared to have been in the wrong; and not a few of those who ardently desired a reform in the College have throughout disapproved of the tactics which the Association of Members adopted. Nevertheless, we cannot withhold sympathy and best wishes for the ultimate attainment of the end in view—namely, that of improving the constitutional position of the neglected Members of the Royal College of Surgeons of England.

It is rumoured that the plaintiffs intend to appeal against Mr. Justice ROMER'S decision. We cannot but conclude that an appeal would serve only to keep up an irritating cause of difference which it is desirable in the interests of both of the Fellows and Members of the College to remove as quickly as possible. It would delay the reforms which are now accessible without benefiting in the smallest degree either the plaintiffs or the Members of the College. Even if it were proved that the Charter of 1800 had been irregularly secured, it would not be possible to go back to the conditions established by the Act of 1745. The cause of reform would not be advanced unless the whole fabric of the Charters and by-laws commencing in 1800 could be swept away and a *tabula rasa* obtained. Then perhaps the claims of the Members of the College to a substantial voice in the management of the corporation might receive due recognition.

If we set aside the hope of assistance from the judicature, there are only two ways in which the desired reforms can be secured—viz., the action of Parliament and the moral suasion which results from strong arguments founded on justice and expediency. At the present time it would be idle to expect any redress from the Legislature. When a new Parliament has been elected and gives promise of stability, it will be time enough to estimate the prospect of relief from legislation. The only course which remains is a temperate representation of grievances and inequalities to the governing body, the enlistment of the sympathies of a majority at least of the Fellows of the College, the electoral body to the Council, and the conversion of the members of the Council of the College. Future success must depend upon the strength of the forces which the Members of the College can bring to bear upon the Council. An association of Members of the College aiming to realise the just aspirations of the Members to a substantial voice in the management of the corporation ought to include every Member who thinks for himself and aspires to something more than securing for himself and his family the bare means of subsistence; the Members of the College must show that they are a united body, and are really in earnest in vindicating their claims; it is by such means as this that they must convince the Council of the College of the justice and the expediency of yielding to them some representation on the Council of the College.

The profession at large fails to take its proper place in the estimation of the public and the Government of the country, because it lacks, and has ever conspicuously lacked, that *esprit de corps* which is the first element in the elevation and success of bodies of men associated for a common purpose. The leaders of the profession have seldom been on the side of the rank and file in their efforts to obtain increased consideration in the corporations or institutions concerned with professional interests. The stocks, the loss of ears, the fines and imprisonment which formerly were at the command of the College of Physicians in dealing with offenders against its laws more nearly represent the spirit in which the upper crust of the profession has regarded the aspirations and ambition of the lower layers. There are no very obvious signs of any abatement of an antagonism which seems to be innate. Professional brotherhood is too often limited to consultations and social gatherings. At other seasons each class fights for its own hand. The forces of the Members of the College, being large and scattered, are not readily mobilised; but if they wish to lift the cart out of the rut in which it is embedded, they must avoid calling upon JUPITER, and put their own shoulders to the wheel. No better or surer way can be suggested than by making the Association of Members of the College so strong that its voice will be recognised as the true expression of professional feeling and opinion.

WHATEVER significance may be attached to the term "masked epilepsy" from a pathological point of view, it is devoutly to be hoped that it is not to be frequently called upon to do duty in criminal cases, either as a shelter from responsibility or as a refuge from punishment. The case of EDMUND OSBORNE, an elderly and delicate-looking man, who was tried before Mr. Justice CAVE at the Central Criminal Court on Jan. 13th, affords an admirable illustration of the incongruity of opposing evidences and opinions as to the presence of a "disease" whose chief characteristic is its obscurity. According to the account of the trial given in the *Daily Telegraph* of the following date, OSBORNE

was placed in the dock on a charge of maliciously wounding his wife with intent to murder her, the allegation being that on Nov. 10th he returned home in a state of intoxication and savagely assaulted the prosecutrix with a poker, inflicting serious wounds. Believing that he had killed the unhappy woman, OSBORNE went to his daughter and announced his intention of giving himself in charge. The contention on the part of the defence was that at the time of the attack the accused was irresponsible for his actions. It was asserted that there was insanity in the prisoner's family, some of whom had suffered from epilepsy, and that it was while under the influence of that malady in its "masked" form that the accused committed the assault. Mr. GROGONO, divisional surgeon of West Ham, explained that victims of this disease betrayed none of the symptoms of ordinary epilepsy, and that a man suffering therefrom would fall down insensible. His Lordship: But so would a drunken man.—Witness: Yes, but you could waken a drunken man, and for your good nature he would probably swear at you, whereas in the other case t would be very difficult to bring him round. In reply to the counsel for the prosecution (Mr. F. FULTON), witness admitted that the diagnosis of the complaint was somewhat obscure. Mr. PITCAIRN, assistant surgeon of Holloway Prison, was of opinion that the accused was perfectly sane on the night in question, and in reply to Mr. MATHEWS, who defended, he remarked that the disease spoken of was usually advanced in criminal cases, and was held in doubt by high medical authorities. Mr. F. FULTON subsequently admitted that he had never heard of such a form of mania as the one in question; but Mr. MATHEWS was very emphatic on the point, and his description (says the *Daily Telegraph*) was calculated to throw terror into the minds of peaceably disposed citizens. "Years and years," he declared, "it may lie dormant in the brain; but if once it shall show itself it will take the form of ungovernable temper, resulting either in suicide or homicide."

The learned judge, in summing up the case, said, so far as he could gather, "masked" epilepsy masqueraded in the form of drunkenness, and the question therefore arose, "How was one to tell these two things apart?" The jury, however, experienced apparently no difficulty of this kind, and found the prisoner guilty, adding that they believed him to have been under the influence of drink at the time, and some of the jurors recommended him to mercy on the ground that "he was a man of excitable temperament." Mr. Justice CAVE, observing that the case came uncommonly near murder, passed sentence of eighteen years' penal servitude. We can well imagine that EDMUND OSBORNE, on hearing his sentence—no light one assuredly—felt disposed to wish that he had been "saved from his friends." It is clear that upon the evidence the jury had no choice but to hold OSBORNE responsible for the criminal act which he had committed.

When irresponsibility is urged in defence of a prisoner and as a plea against punishment for a crime, it ought to be put forward only upon positive evidence of the existence in the accused person himself of such a condition of mind as would render him irresponsible, and not upon flimsy generalities that scarcely leave room for such a thing as crime in human action. Leaving out the question of persons who are habitually criminal-minded, it may in general terms be taken that no civilised man is, mentally speaking, at his healthiest while engaged in committing a crime; there is at the time a special disturbance of his normal mental balance, by exaggeration or defection of one or more of the processes or faculties whose proportionate distribution and operation constitute his mind in its healthy state. Yet such deviation from the individual's normal best is not to be taken as implying disease or irresponsibility, otherwise all social rule and discipline must be set at naught, and give way to the incoherent sanctions of savagery. On the other hand, insanity, whether in company with epilepsy or not, is properly regarded as a disease, carrying with it irresponsibility and demanding special consideration and treatment. But it would be deplorable if this diseased condition, which carries with it irresponsibility, were to be minimised down to such proportions as are indicated in the phrases "ungovernable temper," "excitable temperament," and "masked epilepsy."

The learned judge's belief that in EDMUND OSBORNE masked epilepsy masqueraded in the form of drunkenness, appears to sum up the situation accurately and concisely, and we hope the day is far distant when in criminal cases mere drunkenness will be regarded as a disease, and not as in itself a crime antecedent to the one up to which it was the means of leading.

THE meeting of Parliament and the consequent demand on the columns of our contemporaries will probably tend much to diminish the number of specifics for influenza vaunted in our daily newspapers. At present the number and variety of these are embarrassing. The lay mind must be puzzled what course to take most effectually to foil the malicious microbe that has caused such ubiquitous mischief throughout this country, and, indeed, throughout almost all countries. One morning all that is necessary, either for the prevention or cure of the disease, is a sniff of an aromatic oil; another day the anxious public is assured that a few doses of a sweating mixture, without discrimination of cases, will divest the attack of all its dangers, and meet all its symptoms. Magazine articles are published disclosing not only the author's name, but the way in which he protects himself, and cures all his patients so effectually that they rarely give him any anxiety. A reader cannot but wonder that with such simple theories of the disease an such effective remedies there should be all this amount of sickness, and a demand for medical services seldom, if ever, equalled in this generation. In trying to form and express a judgment on the treatment of influenza we have to confess at the outset that we have no such brilliant successes to announce, and no single remedy to vaunt as meeting every case and every symptom of every case. There is no disease in which it is so easy to satisfy oneself of the efficacy of a pet remedy and the truth of a plausible theory as in the case of influenza. It will be our endeavour to indicate the general management of the disease, based not on the supposition of the existence of a specific cure but on its general nature, the character of its chief symptoms, and its usual course.

It seems not improbable that men in speaking of influenza in the lump are speaking of very different things. One

thing is certain: that the chief mortality which has been witnessed lately, and which has so shocked the public mind, is not the mortality of mere influenza, but of pneumonia, bronchitis, and pleurisy, single or combined. The special character of such pneumonia, bronchitis, and pleurisy is to be inferred from the extensive prevalence of influenza, from the nature of the initiatory symptoms in many such cases, and from the fact that in the same house in which a patient has suffered, and perhaps died, from such complications, others have had ordinary attacks of influenza with little or no complication, and with quick recovery. For the most part such complications have been witnessed in older persons, and the proportion of such cases has been larger in the present outbreak than in the previous ones.

Nothing can be more misleading than for scientific men to write, especially in lay journals, as if all cases of influenza were alike, or as if a remedy that would appear to advantage in short febrile cases of the disease would be equally efficacious in pneumonia. Few cases are more easily managed than the run of influenza cases, especially in young subjects. Rest in bed, light diet, and a draught of citrate of ammonia and syrup will in nine cases out of ten secure the fall of the patient's temperature to normal in twenty-four, or at most in forty-eight, hours. He is likely to be so well as to wish to be up and about. In this he will be hindered by a wise practitioner, who has learnt that mere rest in bed for a few days, varying according to the case and the constitution of the patient, is the surest way of preventing future trouble, of averting sequelæ or relapses, and of securing restoration from that strange nervous and muscular asthenia which constitutes such a marked feature of the disease, and which in so many cases prolongs the convalescence for days or weeks, or even in some cases for months. In most cases the early use of quinine is beneficial. If a tendency to an evening rise of temperature continues, with profuse nocturnal perspirations, a four-grain dose of quinine at 4 P.M., or night and morning, has a steadying effect on the temperature and the sweat glands. The course of the disease is infinitely varied. One patient will have a very foul tongue with absolute anorexia and loss of all taste and smell, for which, with or without the quinine, light laxatives, such as a seidlitz powder or small doses of blue pill and rhubarb pill, are indicated. In other cases the pains are very pronounced in the head, back, or body. They are differently, but very vividly, described. The head and eyes are as if being crushed, the back as if being broken; in the limbs it is as if the flesh were being torn from the bones. Such pains often persist when the temperature has fallen. It is in such cases that antipyrin often seems to act like a charm, and, indeed, rarely fails to give relief in ten or fifteen-grain doses, once or twice repeated. Quinine, antipyrin, salicin, and many other drugs are useful in this disease. But the selection of them should be discriminating according to the idiosyncrasy of the sufferer and the physician's knowledge of the patient and his diathesis. In some cases there is very marked anæmia, and faintness with vertigo on the slightest attempt to sit up or move about, calling for the regular administration of nourishment and stimulants, and a very firm resistance to all premature attempts to resume the erect posture. All physicians must have noticed the severe reverse, almost shock, which many patients experience who have got up too soon or sat too long on the first day or two of their escape from bed. In a considerable number of cases the administration of alcohol very materially helps the patient and shortens his convalescence; and where it is practicable and otherwise unobjectionable, champagne is the form of alcohol which seems most useful. Of course in this, as in all other diseases, the prescription of alcohol is to be regarded seriously, and the physician is to prescribe it under strict conditions of time and dose. But with such limitations its usefulness cannot be ignored.

If the evening temperature in a case of influenza continues to rise after forty-eight hours, some complication is probably present, and it will generally be found in the bronchial tract or in the tonsillar or pharyngeal region. Here evening doses of quinine will be very beneficial, or salicylates, especially in rheumatic subjects, combined, if necessary, with ammonia and other remedies for the relief of the bronchial catarrh, and other local or topical applications. We are not now dealing with those grave cases of pneumonia which have constituted such a deadly feature of this epidemic, and which are so different in their result from sthenic pneumonia in ordinary seasons. It is, indeed, a question whether these should not be regarded as something apart from ordinary influenza, and more of the nature of the epidemic pneumonia in Middlesbrough and other places investigated so ably by Dr. BALLARD two years ago. We should like to see this point definitely investigated.

One of the most disappointing things about influenza is the prolongation of the convalescent stage. The patient continues weak, or short-breathed, or anæmic, or suffers from pains and soreness of the limbs. In many cases such sequelæ are due to treating the disease too lightly in the first instance, to an insufficient period of rest and recumbency, or an inadequate use of tonics proper to the diathesis of the patient, or else to neglect of seeking change of air; for here, as everywhere else, it is the patient, and not the mere disease, that has to be treated. All patients cannot be treated with one remedy or in one way; they "need a physician"—in other words, one who will go into the particulars of their case, and select from half a dozen remedies the one which they require. But here, again, the medicine or drug is only a small part of the treatment necessary to remove symptoms so deep-rooted and persistent. It is by discriminating treatment, and not by the wholesale prescription of any nostrum, that the welfare of patients and the reputation of the profession are to be secured.

THE more recent telegraphic despatches which have been made public concerning the proceedings of the International Sanitary Conference at Venice have been difficult to understand, and have seemed to indicate some considerable vacillation in the attitude of the British delegates, who, as announced, have been in frequent communication with the Government on the subjects under discussion. As will be remembered they went out to uphold the principles of the Anglo-Austrian protocol, which demanded the passage "in

quarantine" of the Suez Canal for all British vessels regarded as "suspect" or infected, provided these did not communicate with land until arrival at their port of destination; and the same privilege was to be accorded to any other nation which desired to make arrangements accordingly. This protocol had the appearance of having been very deliberately prepared by our Foreign Office, which department selected the delegates who were to represent the interests of this country, and it was generally understood that its terms met with favour on the part of the Italian Government. The French counter proposals now appeared on the scene; and without any explanation that could be regarded as reasonable, unless a mere counting of votes be so regarded, it was announced that these proposals had superseded the English ones, and had, with certain modifications, been assented to by our delegates. The two sets of proposals differed in the most important of all the conditions laid down. The one demanded the passage of the canal for all our troopships, mail-boats, &c., even if infected, provided they sailed direct to a British port; the other not only refused this passage, but in certain cases demanded an old-fashioned quarantine, by requiring the disembarkation and detention of all the passengers &c. at the Wells of Moses in the case of infected vessels. Then came adjournments, during which the public were informed that the British delegates were in communication with the Home Government; and this was followed by an urgent telegraphic despatch to the chairman of the Peninsular and Oriental Shipping Company to join the delegates at Venice, but before his arrival these arrangements, which had apparently been agreed upon, were again modified, and some of the French proposals were practically set aside.

Then towards the final stage of the proceedings came a further telegram, to the effect that the proposals which England had laid down "regarding the passage of the Suez Canal in quarantine" had been adopted with certain amendments and assented to by the Conference. There still remained such reservations that the British delegates declined to sign the convention which had been prepared until they had received authority so to do from Her Majesty's Government. And this refusal is the more significant, because the latest telegram as yet received states that amongst other things adopted by the Conference is "the detention at Moses' Wells of all infected vessels—that is to say, of those which actually have on board cases of cholera or have had them some days previously." It is true that this is further limited by a reference to the disembarkation of the sick only; but, on the other hand, the same regulation definitely refers to a detention which, as regards the ship—not the passengers—will, in any event, not exceed five days. The arrangements thus provisionally proposed or entered into seem most perplexing, and it will be impossible to form a proper judgment upon them until the actual terms of the Convention have been made public. If Great Britain has seen fit to sanction an alteration in the constitution of the Alexandria Board, by which it acquires an international character, and if our troopships and other ships are to disembark "the sick" at Moses' Wells, it is earnestly to be hoped that the officials who will have the power of deciding who is to disembark shall be such as this country will have confidence in, and that no such measures shall even be commenced until we know that adequate provision has been made for the care of those who are detained.

THE general meeting of the Council of the Hospital Sunday Fund, which was held on Monday last, had a long list of distinguished names to record with obituary references, the deaths of Sir J. RISDON BENNETT, Cardinal MANNING, and Mr. SPURGEON having followed one another in very rapid succession, and it was with very sincere feeling that the Council testified to its sense of the great services which these men had rendered to the common cause. The resignation of Sir RUTHERFORD ALCOCK was also announced. But the chief business of the meeting had reference to the form of hospital accounts which has been elaborated by a committee of hospital secretaries, and provisionally approved by the Council of the Fund for adoption by the various hospitals in rendering their accounts to the Distribution Committee of the Fund. The prevailing feeling at the meeting of the Council was that, for the sake of obtaining uniformity it was worth while to make a beginning with a form of accounts, even though it should have to be hereafter modified, so great is the inconvenience felt by the officers of the Council in dealing with the various forms which are at present received from the hospitals of the metropolis. The need of fuller consideration and the possibility of consequent revision before the schedule can take a final shape were clearly recognised, and this without the slightest disparagement of the painstaking and prolonged work of the committee of hospital secretaries, which has elaborated the present form. That committee has held numerous sittings, and has continued its labours through many months, at what must have been to its members a considerable sacrifice of time and trouble, for which no acknowledgment beyond the thanks of the Council has been or could be offered to its members. It has brought to bear upon the task a large amount of very special knowledge, and the result will command and will receive in all subsequent discussion the most careful consideration, and upon many points will doubtless be accepted as authoritative. The only reason that the work cannot be at once accepted as final is that there are matters to be taken into account which the secretaries' committee did not and could not include in its discussions. The hospital view of the aim and function of the published accounts is a very important one, and the only one which the secretaries' committee could be expected to take of its subject. But it is not the only possible view. When a communication passes between two parties there are naturally two views of it—the view of him who makes and the view of him who receives the communication. In the matter of annual statements, which are communications between the hospitals and the public, we find embodied the views of the one party, ascertained and expressed by what we have every reason to believe is a very efficient representative committee. But no one approaching the subject from the point of view of the public has as yet been consulted by the Council of the Fund; and our own examination satisfies us that when this

is done it will turn out, as one would naturally expect, that there are things to be considered in the determination of the schedule which do not naturally suggest themselves to the official mind. The officers desire to speak and the public desire to hear one and the same thing in substance, but in its presentation these are chiefly concerned with difficulties of expression and those with difficulties of apprehension. Both therefore can contribute matter of substance to the discussion, and we reserve a final approval of the form until all available information on the subject has been garnered and thrashed out.

This view of the matter has acquired a special importance at the present time from the circumstance that the House of Lords Committee upon Metropolitan Hospitals has taken evidence upon this subject, and will doubtless deal with it among other matters in the forthcoming report. To any such utterances great consideration will of course be given, and if various forms of statement should come in the end to be competing for recognition, it might well happen that the last state of confusion would be worse than the first. It is plain that the hospitals cannot be asked to serve up one set of accounts to one authority and another set to another authority. Eventually, it is to be hoped that a schedule will be devised that will satisfy all the exigencies of the case and command common consent. The need of uniformity is now pretty generally recognised, and it ought not to prove an impracticable undertaking to devise the schedule which will be on the one hand comprehensive and elastic enough to suit all the hospitals, and on the other hand sufficiently perspicuous and precise to convey full and intelligible information to the ordinary reader.

Annotations.

"Ne quid nimis."

THE ALBERT UNIVERSITY.

DURING the past week an important event has happened with regard to the proposed Teaching University in London. As a result of some negotiations between the authorities of King's and University Colleges and the Joint Grand Gresham Committee, the latter body has unanimously resolved: "That this committee are willing to coöperate with University and King's Colleges and the medical colleges of the great hospitals in London in the establishment of the proposed University in and for London on the understanding that it be called the Gresham University." This proposal will doubtless be adopted by the Councils of King's and University Colleges, and we anticipate that no objections will be raised by the medical colleges, whose delegates will also meet the representatives of the teaching colleges this week, so that a combined action may be taken with regard to the passing of the Charter through Parliament. A mere change in the name, although this is a decided improvement, is the least of the advantages that will be derived if the offer of the Gresham Committee be accepted. The name of Sir Thomas Gresham is pre-eminent in the history of the University movements in London; for as long as some 300 years back he devoted his wealth to founding Gresham College as a Teaching University in and for London. This College will now become such a University, and the numerous bodies represented in the scheme of the University will have a common centre and a home for the meetings of the constituent members. On the other hand, the City will have a University in its midst, where, indeed, a University in and for London should be, and the reproach to this metropolis, that with the exception of Constantinople it is the only capital in Europe without a Teaching University, will be removed by Gresham College becoming the headquarters of the proposed University. It is believed that the change of name can be made before the Charter is submitted to Parliament, as it will doubtless have the consent of all the constituent Colleges, and as the Privy Council intimated in their final decision that the name was open to reconsideration. No other change, we understand, is contemplated in the Charter.

OFFICIAL INQUIRY INTO INFLUENZA.

FOR some weeks past it has been evident that a demand exists both on the part of the public and of the medical profession that further investigation should be made into the subject of epidemic influenza. The report issued by Dr. Parsons last year was admirably summarised in an introduction from Dr. Buchanan's pen; but whilst it settled the question of the infectious character of the disease and of its communicability from person to person, and thus carried with it, by implication, the need for the adoption of the ordinary precautions against a disease spread by such means, it was in many other respects an avowed confession of the lack of knowledge and a plea for further inquiry. "For the better means of repressing influenza," wrote Dr. Buchanan, "our expectation must be in an understanding of the natural history of the disease." Some eight months have elapsed since those words were written; the disease has recurred, and this in a very fatal form; but it has evidently needed the influence of outside public opinion to secure the continuance of the inquiry which was officially proposed. The delay is clearly not due to any lack of desire on the part of the Local Government Board to perform the duty devolving upon it in the matter; but the grant for scientific research allotted to the Medical Department is notoriously determined on a scale which is mainly characterised by rigid economy, and no special work of the sort needed can ever be contemplated except as the result of a special grant. This has at last been forthcoming, and it is to be hoped that it has not come too late to be of real service. The funds thus tardily entrusted to the Medical Officer of the Board will be, in the first instance, devoted to a study of the clinical features of influenza, to investigations as to its special pathology, if any, and to bacteriological research. These are the right lines; and, fortunately, a number of experts accustomed to the more scientific portion of the work are already available, and have already done good work, under Dr. Klein, in investigations of a somewhat similar character, as regards the relation of scarlet fever and diphtheria in the human subject to disease in the lower animals. From the more general and clinical portions of the inquiry we may expect information which will assist in ensuring a differential diagnosis of the disease, in obtaining some more accurate knowledge as to its period of incubation, and a better insight into its pathology. On such information only can any trustworthy means of prevention be based. As regards the present aspect of the epidemic, it is rather to prophylactics, if any exist, and to remedial measures, that we must look; but this subject comes more within the province of such a body as the Royal College of Physicians than of a department dealing solely with public health considerations.

LIFE-SAVING AROUND THE COASTS.

No part of our telegraphic system now in existence could exceed in utility that which would be added to its range of usefulness if electrical connexion were established with the coastguard and life service depôts distributed around our coasts. When we reflect upon the certain benefit which a project of this kind, if successful, must confer upon us as a maritime people, it seems at first sight incredible that up till the present date almost nothing has been done towards its execution. This neglect, short-sighted and discreditable though it is in more ways than one, is after all not wholly out of keeping with our national conditions. With us, untroubled by disputed frontier questions, the value of a method of communication is apt to be at first, and perhaps for a long time afterwards, judged of by its social convenience and its influence on business only, and the telegraph has accordingly been but little considered in relation either to coast defence or the dangers of coast navigation. It will now, however, be readily conceded that the claims of society and our daily occupations have in regard to this matter been duly allowed for. It is time, and high time, that some practical attention should be given to other and even greater, if not equally constant, necessities. The history of the recent winter storms will recall several sad instances of shipwreck with loss of lives which might and probably would have been saved had a wire been available to summon the earlier services of the lifeboats. A similar argument, of course, holds good in the event of a descent by hostile ships upon our coasts. It is estimated that £100,000 would defray the cost of putting all coastguard stations in night and day wire connexion with the general system, and a series of letters dealing with the whole question have been submitted by Mr. F. H. Maberly, late assistant surveyor, General Post Office, to the Queen, the various Chambers of Commerce, and the members of both Houses of Parliament. The scheme has already been widely approved, and we cannot doubt will at no distant time find that issue in practical reforms to which it is entitled by its great and obvious importance.

TYPHUS FEVER IN LONDON.

MR. SHIRLEY MURPHY, the medical officer of health to the London County Council, has issued a valuable report upon the prevalence in London of typhus fever, which shows to how great an extent this disease, once so common, has been disappearing from the metropolis, thanks, no doubt, in great measure to improved sanitation and the greater vigilance of the authorities. Nevertheless, this diminution of a total of 92 deaths in 1881 to 11 in 1890 must not be allowed to lull us into a false sense of security, although the sparsity of outbreaks and the masked features of some cases may lead to certain sporadic instances being overlooked. This is well illustrated by the record given by Mr. Murphy of an outbreak of the disease in a narrow, ill-ventilated court in St. Olave's, called Sards'-rents, to which his attention was called in October of that year by Dr. Wightwick, the medical officer of health for that district. The inhabitants were of the poorest class, and were occupied chiefly in pulling out of hair from skins. Since January, 1890, there had prevailed amongst them a disease characterised by pneumonic symptoms and delirium. One patient had been removed in March to a public institution and had died there, the death being registered as due to pneumonia. Another had been removed to a general hospital in August, and died from "bronchitis and emphysema." When Mr. Murphy first inspected the court he saw only some children who were recovering; but a few days later other persons sickened, and a careful examination of these cases along with Dr. Wightwick led to the conclusion that the disease was not pneumonia. Although no cutaneous eruption was present, they were forced to the suspicion of typhus fever, an impression confirmed by a study of the recorded history of the hospital case. Therefore, all cases subsequently arising were removed as soon as they occurred, and the suspicion of typhus fever was confirmed by their clinical course. It is satisfactory to learn that some of the houses in Sards'-rents have been demolished under Torrens' Act. Dr. Wightwick estimated that from thirty to fifty persons had been attacked in all, and in November and December eight cases occurred in another street, the outbreak there being doubtless imported by a relative of one of the Sards'-rents people who had nursed them during their illness. The introduction of the Notification Act led to thirty-five cases being certified in thirty districts of the metropolis in the year 1890; but of these only fifteen can be regarded as indubitably typhus, to which number five must be added which are returned as enteric fever. One case occurred in Bermondsey, in the same street as was affected at the end of 1889, and is probably referable to the same outbreak; whilst from March to June there were four cases in one family in another street; and, six months later, a more doubtful one in a third street of the same district. As to 1891, the report states that during the first nine months twenty-six cases were certified from fourteen different districts; but of these eleven proved not to be typhus fever and four others were doubtful. But at least twenty-four other persons suffered from typhus fever—not at first recognised. Particulars are given as to the chief cases, ten being certified at Holborn; but we have said sufficient to show that Mr. Murphy's opinion that typhus fever is evidently very ill recognised is justified, and we may especially draw attention to his admonition that "cases of ill-defined fever must be regarded with suspicion at the present time."

A WORKMEN'S SANITARY CONGRESS.

THE French labour party have determined that their Ninth Annual and National Congress shall be devoted to the discussion of one single subject. Up to the present all sorts of subjects have been discussed at these congresses, resulting in the proclamation of abstract principles and the adoption of ideal programmes. As everyone is now agreed as to the general principles that should govern the party, it is felt that something more precise and more practical should be attempted. The party has its representatives in Parliament, in the Paris Municipal Council, in the legal courts of arbitration, and in provincial local assemblies. These representatives should receive distinct instructions on practical legislative questions especially affecting the welfare of the working classes; and the annual Congress, instead of discussing a little about everything, has determined to devote the whole of its time to the careful study of one of these questions. It was of course somewhat embarrassing to decide which question should thus be considered, to the exclusion of all others; but it was ultimately resolved to give the preference to hygiene in its relations to the working classes. The debates of the Congress will be divided into three different phases of this great subject. First will be taken the problem of food-supply, especially in reference to the laws of March 27th, 1851, and May 5th, 1855. The workers will demand that the quality of the bread they eat shall be as carefully guaranteed by the State as the quality of the gold of which the current coinage is made. The second question relates to the sanitation of the worker's home, when the futility of the Commission on Unwholesome Dwellings will be dwelt on. The last subject is the sanitation of the workshop and factory, when the decree of 1810 will be denounced in no measured terms. According to this law the public

are protected against dangerous industries, but not the workers. Thus, lead works are put in the second category, because they do not give rise to injurious emanations, and are only injurious to the workmen themselves. Such will be the general scope of the Congress; but before the delegates of the trade unions and the workmen's societies who form the labour party discuss these problems they will invite the best known scientific authorities on hygiene to deliver addresses to the Congress so as to enlighten the delegates as to the technicalities at issue. This precautionary measure is at once as wise as it is modest, and denotes considerable discretion and tact on the part of the workmen. They will find a scientific basis for their demands and make their wants known to men of science. Thus the sympathy that already exists between workers with the brain and workers with the hand may be further developed, and to the great advantage of public health.

POSITION OF THE NOSE.

DR. SIMONTON, in the *Chicago Journal*, calls attention to the fact that the human nose is frequently not in the centre of the face, and he emphasises the importance of this fact with reference to the accurate fitting of glasses. The difference in the breadth of the two sides varies from one-sixteenth to one-eighth of an inch, but he has not found it more than an eighth. But such a difference, he says, is sufficient to cause much trouble and inconvenience, especially with somewhat high refractive errors, unless the glasses are accurately ground with reference to the actual position of the pupil. Any adaptation of the spectacle frame, he says, would upset their balance, so that the glass should be modified, if such an inequality, as he says is not uncommon, should exist.

DOES INFLUENZA PROTECT FROM A SUBSEQUENT ATTACK?

THE question whether an attack of influenza confers protection from subsequent infection is one which must have often arisen during the experiences of the last three years, but the data for its solution are not yet fully available. The amount of information which must have been gleaned by the family practitioner in all parts of the country upon this and many other points concerning the malady would, if collated, go far to settle the matter. It is of course notorious that certain individuals have suffered from more than one attack; but the conviction is pretty general that such cases really form but a small minority of the large numbers who have suffered. Then, again, it must be deemed possible that the degree and duration of the protection may depend on the severity which the primary attack exhibited, for one can hardly invoke the doctrine of attenuation of virus in the case of this disease, which shows so much variation from the ordinary course of infective disorders in general. In a highly interesting contribution upon the features of the present epidemic in Berlin, Dr. Ruhemann[1] directs especial attention to this question of protection and affords valuable evidence of it. He aptly remarks that the more gradual evolution and persistent character of the present epidemic, as compared with the rapid and stormy course of the pandemic of 1889 to 1890, have afforded opportunity for more closely studying the characters of the malady, and that it has especially enabled us to recognise more clearly its contagious nature. According to him influenza has prevailed in Berlin ever since the beginning of last September, and he notes how on this occasion the stress of the outbreak has fallen to a far greater extent upon women and children and less upon men than was the case two years ago. His own practice affords proof of this, especially in the fact of the greater frequency of uncomplicated cases among women than among men. As to the question of protection, he has observed that members of families who were severely attacked two years ago have either escaped entirely at present or been only slightly affected; whilst, conversely, the most serious cases of the present time have arisen in households which the influenza spared during its earlier visitation. He notes the statement of Dr. Edw. Gray,[2] to the effect that "many persons who escaped the epidemic of 1775 were affected by that of 1782, and many who escaped the latter were affected by the former," as showing that a century ago this question of immunity had not passed unnoticed. Dr. Ruhemann gives his own experience of 55 families, numbering 193 individuals. In 1889–90 there were 64 cases of influenza among this group, whilst in the present outbreak only 40 have been attacked, and, what is of especial interest, only 5 out of this number were affected (and that but slightly) two years ago, whilst of the 64 then attacked, only 4 have again become victims. Should this prove to be anything like the general experience it would go far to substantiate a fact that has hitherto been much disputed, even to the extent of declaring that one attack predisposes to another. That one individual may have several recurrences during the prevalence of a single epidemic does not, in Dr. Ruhemann's opinion, mitigate against the general doctrine of protection, since he thinks many such recurrences may be explained by lack of caution on the part of patients against exposing themselves to fresh infection before they are restored to full health. That influenza does protect from a second infection should reassure many persons who, having once suffered severely from it, dread a repetition of so depressing a malady; and it may be a further comfort to them to learn that the more they have suffered at first, the less likely are they to suffer at all again. If, then, influenza shares this common property of all infective diseases, it is not so remarkable that it should not apparently select the young in preference to the adult and aged, seeing that the whole community is more or less "unprotected" when it first reappears after an absence (in pandemic form) of years.

[1] Deutsche Med. Wochensch., Jan. 28th.

THE MANCHESTER MEDICO-ETHICAL ASSOCIATION.

WE have been favoured with the forty-fourth annual report of the Manchester Medico-Ethical Association. It reports "a spirit of activity" in the work of the Association. By way of increasing the interest of members and usefulness of the Association, the committee ventured to initiate an extension of the usual programme by securing a series of papers on the following questions of public interest:—A Presidential Address on Infant Mortality, by Dr. Ashby; the Disposal of the Dead, by Dr. Wahltuch; the Relation of Unhealthy Dwellings to the Etiology of Phthisis, by Dr. T. Harris; the Influence of the Drink Traffic on the Death-rate, by Mr. Meacham; and the Laws and By-laws regulating the Sanitary Arrangements of the City of Manchester, by Dr. J. Tatham. The attendance at the reading of these papers was very good. The committee took an active part in opposing the Midwives' Registration Bill, and in drawing attention to serious defects in the Factory and Workshop Act. On the subject of increased representation of the profession on the Medical Council the subcommittee suggested that it should be secured rather by some of the Crown nominations being given to members of the profession in general practice than by mere addition to the numbers of the Council. Not the least interesting question mooted in the Society was that

[2] Thompson's Annals, p. 110.

of establishing a black list. The question was referred to a subcommittee, which took counsel's opinion thereon. The subcommittee consider counsel's opinion to be in favour of such a list, but they think that it will require to be so carefully drawn up that the whole question should stand over for consideration next session. The profession will await with interest the further action of the Association in this delicate matter.

A LIFE FOR A LIVING.

AFTER another period of remarkable abstinence, lasting to within a few hours of forty-four days, and maintained in spite of gastric irritation, severe cold, London fog, and the indifferent atmosphere of his apartment, the Italian Succi, has found it needful to give way to nature, and to forego the last week of his self-allotted fast. We have no regret for this result, but rather for the fact that he will still persist in enduring for a time a modified starvation on lemons, oranges, and water. During the period above mentioned he has lost almost a third of his body weight, and has, it is clear, come within a hair's breadth of actual suicide. Why? For this is the essence of the question whether such performances are justifiable or not. For the settlement of scientific doubts, shall we say, or the proof of moral supremacy over appetite? No, these ends have already been attained by precise methods of research and by personal experience. If, therefore, such excuses be urged in the present connexion, we need not look far for the means of refuting them. The fasting man, as we now find him, is no recluse or companion of a few skilled observers merely. He is the constant notoriety of show companies, the central interest of curious crowds, and, finally, the sharer in substantial money profits. With him abstinence is a mere business, needless and dangerous in itself, detrimental to the discharge of more fruitful duties, and certainly not elevating to the moral sense of onlookers. As much may be said of the woman reported to be similarly employed in Paris. The prohibition of such disgraceful and inexcusable exhibitions would be nothing less than a public benefit.

THE DEATH-RATE IN GREATER MANCHESTER.

DURING the year 1890, when the death-rate in the city of Manchester, as it then existed, was for a considerable time above the high rate of 30 per 1000, the efforts of the Corporation to extend its limits were crowned with success. This success afforded the opportunity to certain ill-advised persons to declare that the high death-rate was merely a fallacy, mainly due to the artificially restricted boundaries of the city, and to assert that this extension would so reduce the death-rate as to prove that the excess of Manchester mortality, about which so much fuss had been made, was merely the result of a faulty system of mortality statistics. The extension came into operation, so far as the vital statistics of the city were concerned, on Jan. 1st, 1891, and its effect was to add to the population under the sanitary control of the City Corporation more than 100,000 persons. It will not be without interest to refer briefly to the mortality statistics of what has been called Greater Manchester for the year 1891, and to compare it with the figures relating to Old Manchester for preceding years. This interest will not be lessened from the fact that in certain local quarters much jubilation has been expressed because the Manchester death-rate has in recent weeks compared much more favourably with the rates in the other large English towns than was the case in 1890, before the last city extension. This, as can easily be proved, is not due to any remarkable decline in the recorded death-rate of Manchester, but to the fact that so many of the large towns have in recent weeks been suffering severely from the direct and indirect effects of the present influenza epidemic, from which, so far, Manchester has been comparatively free. The Registrar-General's quarterly return for the last three months of 1891 enables us to state that the death-rate of Greater Manchester was last year equal to 26·5 per 1000, which, although 3·2 per 1000 below the disastrously high rate in 1890, was only 0·1 below the mean annual rate in Old Manchester during the ten years 1881–90. It would have been thought that such an infinitesimal result on the death-rate from the inclusion of so large a suburban area within the city would have been a serious discouragement to those who never tire of writing on the so-called "fallacies about our death-rate." This discouragement becomes the more serious when it is admitted that the inclusion of this large suburban population cannot have been without effect in reducing the death-rate, from which it follows that the death-rate in Old Manchester last year must have been, if not as high as in 1890, considerably above the mean rate in the ten years 1881–90. The death-rate from "fever" (mainly enteric or typhoid), as well as from diphtheria and from whooping-cough, was considerably higher last year in Greater Manchester than the mean rates from the same diseases in Old Manchester in the ten preceding years. So with infant mortality, which was equal to 192 per 1000 births last year in Greater Manchester (although the diarrhœa rate in 1891 was low), whereas in Old Manchester the mean rate of infant mortality during the ten years 1881–90 was 179 per 1000, a rate far in excess of the rate in most of our other large towns. If we compare last year's death-rate in Greater Manchester with that in Greater London, the result is not more satisfactory to those who have to live in Manchester. The Greater Manchester rate was, as we have stated, 26·5 per 1000, while in Greater London the rate was only 19·6. This signifies that during last year, of equal numbers living, 135 persons died in Manchester to each 100 dying in London. To those who can read aright the logic of these figures, last year's mortality statistics of Greater Manchester abundantly prove that there is no fallacy in the excess of Manchester mortality. We shall look with much interest for Dr. Tatham's report on the health of the city in 1891, which will probably throw some useful light upon the local assertions that the high death-rate of the city is merely the result of fallacy.

CASE OF SHOCK FROM A TELEPHONE WIRE.

DR. JOSEPH COLLINS relates in the New York *Medical Record* a curious accident which happened to a patient of his. The latter was a man of thirty-one, who in September, 1890, was engaged in repairing a telephone wire, and while so engaged he received a shock through having touched a wire at a point where it had become accidentally uninsulated. He said that for two or three seconds he retained consciousness, and at this time he had no pain, but a sensation that he was filled with something, and a conviction that as soon as that sensation ceased he would die. He lost consciousness, fell down about twenty-five feet, and struck on a butcher's cart between the wheel and the body of the vehicle, thence falling to the ground on his head and neck. On recovering consciousness, which he did in a very short time, he was a little dazed. He had great weakness of his shoulder, and this became worse. At first the faradaic reaction was retained in his deltoid, but it disappeared later, and again returned, and he regained the use of his shoulder. He subsequently, however, developed numbness of one side and hemi-anæsthesia—a condition apparently functional in character, from which he recovered after being hypnotised. After the accident he also had two large burns, one on the left side of his neck and the other

on the postero-internal surface of the upper third of the tibia, these being apparently the result of the actual contact of the wires. The paralysis of the deltoid was no doubt due to an affection of the circumflex nerve, but there seems to be no reason for connecting this in any way with the electric shock. It is with more likelihood to be regarded as a result of the fall upon the shoulder.

WORKHOUSE INFIRMARY NURSING ASSOCIATION.

THIS Association was begun in 1879 with a view of, among other improvements, securing the appointment of trained ladies as matrons in all separate infirmaries, and to train and supply nurses to workhouse infirmaries in London and the provinces. The committee, consisting principally of gentlewomen, call attention to the importance of employing trained ladies as matrons in these institutions, and to the advantages which would accrue to the infirmaries if a system of training probationers in the general wards, and also in the lying-in wards of the infirmaries, were adopted in each. By a trained nurse is understood a person who has received at least one year's training in some approved general hospital or infirmary. Three years' training and experience in an institution for the sick is, in the opinion of the committee, very desirable for charge nurses. The committee have also formulated some very obvious axioms on the nature and effects of permanent night-nursing duty, and they make suggestions thereupon. The hours of daily recreation of nurses are, it is proposed, to be altered, on moral and hygienic grounds, from the evening to the afternoon.

INFLUENZA AND SALICIN.

IN the *Nineteenth Century* Dr. T. J. Maclagan has written an article under the above heading, and as it is sure to be widely read and eagerly discussed, it may be well to give in these columns some idea of the way in which the subject is treated. The conclusions may be very briefly stated—viz., that the poison of influenza is of malarial origin—a miasm, and therefore an organism; that there is not a little evidence to show that salicin in full and frequent doses cures influenza more rapidly than does any other mode of treatment, and that salicin seems also to exercise some protective influence, "ten grains three times a day for many weeks" being the dose recommended for this purpose. These conclusions are, however, preceded by many pages of matter even more open to criticism. In popular form the writer endeavours to explain the mysteries connected with the evils wrought by the reproduction of organisms within the body, and also to demonstrate that, even in the absence of microscopic proof, the belief in the existence of organisms may be derived from a study of the natural history of the diseases to which they give rise. In the course of his argument he mentions briefly the phenomena connected with the rapid reproduction of minute organisms, citing malarial fever, pneumonia, and rheumatic fever. Then he explains that the locality in which each parasite finds the special something required for its growth is technically called its nidus, and states that the time required for the exhaustion of the nidus varies in different diseases, but that the nidus, once exhausted, is, as a rule, never replaced. Here the desire to be lucid has led to error. One attack of rheumatic fever rarely stands alone, as it should do if the nidus were exhausted; and, moreover, with regard to pneumonia, it would be surely rather slipshod pathology to speak of a lobe of the lung as a nidus which, once exhausted, is never to be replaced. In further elaborating this view, he states that "the nidus of the poison of typhus fever is exhausted at the end of two weeks, and that if we can keep the patient alive for that time he will recover. We know that in typhoid fever it takes three weeks to exhaust it, and if we can tide the sufferer over that time he will get well." Would that this were true! Although Dr. Maclagan finds it necessary to speak thus hopefully of the later weeks of typhoid fever, experience does not confirm this. It is to be regretted that Dr. Maclagan's conclusions were not submitted for discussion in the medical journals, rather than in a lay publication, and without being encumbered with so much hasty and debateable material.

DEATH OF SIR MORELL MACKENZIE.

WE regret to announce the death of Sir Morell Mackenzie, which occurred suddenly on Wednesday evening at 10 P.M., at his residence in Harley-street, from syncope, following an attack of influenza. He was the most distinguished laryngoscopist in this country, and his practice was very extensive. When in his twenty-sixth year he was awarded the Jacksonian prize by the Royal College of Surgeons for his essay on the pathology and treatment of diseases of the larynx. Sir Morell Mackenzie attended the late Emperor Frederick, and it was in recognition of his services on that occasion that the Queen in 1887 bestowed on him the honour of knighthood. The Emperor also conferred on him the Grand Cross and Star of the Hohenzollern Order.

NOTIFICATION FEES AT CHELSEA.

A DISCUSSION that will require much justification has been raised in the Chelsea Vestry on the following motion: "That the question of payments of fees by the parish of Chelsea under the Notification of Diseases Act be referred to the Law Reference and Sanitary (Joint) Committees to take into consideration if some steps should not be taken to prevent some medical men in the parish from making returns that are considered unsatisfactory." It appeared to him most astounding that, from the figures published, practically three gentlemen received all the cases of infectious diseases in the parish. The mere fact that certain medical men have a larger number of infectious cases than others is not very remarkable. It is not much more so that a medical man should have more—perhaps double the number—in one quarter than in another? One of the speakers seemed to blame more those who do not report than those who report so many. It is difficult to please the Chelsea Vestry.

PENTAL AS AN ANÆSTHETIC.

BRENER, in a communication to the Royal Medical Society of Vienna, reports having used pental as an anæsthetic 150 times in his dental practice. Loss of sensation is produced before complete loss of consciousness. Usually the patient recovers quickly and easily. The effect is produced generally in one or two minutes, and requires ten to fifty grammes. According to Rogner in the *Wien. Med. Pr.*, 1891, and Hollander in *Nouv. Rem.*, 1891, the loss of sensation lasts about four minutes, and towards the end of the seventh minute passes away. There is no vomiting or other troublesome symptom during the inhalation, nor does headache or sickness occur afterwards. The loss of consciousness comes on during the first few minutes with complete loss of voluntary movement. Rogner considers it the best anæsthetic to use in minor surgery. In spite, however, of these favourable reports, Brener himself had a serious accident. A girl who required extraction of a tooth was placed under the effect of pental. She had only taken four grammes when alarming symptoms arose—syncope, apnœa, loss of pulse, and dilatation of the pupil. It was necessary to resort to artificial respiration to restore con-

sciousness. This fact, as Basch and Dittel observe, proves that new anæsthetics, and especially those producing rapid narcosis, require great care in their employment.

A SANITARY ASSOCIATION FOR LEEDS.

THE sanitary condition of Leeds has attracted a good deal of local attention and comment, and under the support of the mayor, Dr. Cameron the medical officer of health, and many other prominent citizens, a meeting was convened last week, at which it was decided, on the motion of the vicar of Leeds, to form an association to coöperate with the sanitary authorities for securing improvement in the circumstances of the borough. The objects of the association as at present formulated will be to influence public opinion in Leeds on sanitary matters, to assist in bringing sanitary deficiencies to the knowledge of the proper authorities, and generally to promote sanitary improvements in the borough. The assistance of ladies is also to be secured. The association will, in all essential respects, resemble the parent one in Manchester and Salford, an association which has done much good, and which has always secured the hearty coöperation and support of the medical officers of health of the two important communities in which it has laboured.

ROYAL COLLEGE OF PHYSICIANS.

AT a meeting of the Royal College of Physicians, held on Thursday, Jan. 28th, the following gentlemen were nominated to act as a Committee for the Revision of Nomenclature of Diseases, a work which is undertaken by the College of Physicians every ten years. Besides the President (Sir Andrew Clark) and the Registrar (Dr. Edward Liveing) (*ex officio*), the committee will consist of Dr. Bristowe, Dr. Hermann Weber, Dr. Pavy, Sir W. Roberts, M.D.; Dr. Buchanan, Dr. W. Ogle (London), Dr. Gee, Sir Dyce Duckworth, M.D.; Dr. Stevenson, Sir Joseph Fayrer, Dr. R. Liveing, Dr. T. Buzzard, Dr. J. F. Payne, Dr. D. Hack Tuke, Dr. Thorne Thorne, Dr. Ord, Dr. Cavafy, Dr. T. Lauder Brunton, Dr. Frederick Roberts, Dr. Sansom, Dr. Galabin, Dr. Champneys, Dr. Dreschfeld, Dr. Savage, Dr. Tooth, Dr. Greenhill, and Dr. Perry of Guy's Hospital, with power to add to their number. Certain surgeons have also been invited to assist the College in the carrying out of this work, but their names have not yet been made public.

INFLUENZA IN CHILDREN.

THERE seems to be a prevailing impression that infants and young children are not attacked by influenza. That this idea is wrong, however, many practitioners can testify; it is naturally difficult to diagnose in such patients, but the fact that they sicken when their parents or nurses are affected with the disease is strong presumptive evidence that they also are attacked. Dr. David Fuchs of Budapest is of this opinion, and publishes a short article on the subject in the *Allgemeine Wiener Medicinische Zeitung* of Jan. 19th of this year. He states that he has met with many cases of influenza in young children, but that the symptoms and course of the disease differ in some particulars from those occurring in the adult. As a rule the attack is lighter. It commences with fever, and the onset is sudden. One day the child may be perfectly healthy, whilst on the next it is severely ill without any prodromal symptoms having developed. The temperature does not generally rise above 103° F., though it may occasionally be as high as 104°. After lasting twenty-four hours the fever commences to subside. With many children cerebral symptoms predominate. Dr. Fuchs records one case in which a child, aged eighteen months, was without any warning seized with severe laryngeal symptoms, followed by convulsions, whilst the temperature rose rapidly to 104°. Vomiting is a very common symptom. Next in frequency come affections of the mucous membranes. The conjunctivæ are injected, and there is catarrh of the throat and nasal passages. In this stage the general appearance is very similar to the early stages of measles. The tongue is coated, and the child gradually subsides into an apathetic state. Older children complain of severe headache. The bowels are usually confined. There is not unfrequently a peculiar rash; it appears on the trunk and lower limbs, and takes the form of small papules not unlike the exanthem of varicella. Its extent varies greatly, and the number of spots may be very few or the reverse. In one child eighteen months old a few small pemphigus vesicles appeared on the backs of the legs, which were at first filled with a clear fluid, but afterwards dried up. Bronchial catarrh, usually slight, frequently follows. After these symptoms have lasted a few days, the temperature becomes normal, and the inflammation of the conjunctivæ and nasal mucous membranes disappears. The other catarrhal phenomena last longer, and the troublesome cough is difficult to get rid of. The exhaustion is considerable, and even after an illness of only three days a strong child will be very much pulled down. The prognosis is in nearly all cases favourable. Although weakly children suffer more than those who are stronger, serious complications rarely set in, and pneumonia is but rarely met with. The treatment is symptomatic, and Dr. Fuchs advises that no antipyretic drugs should be given, as they only tend to depress the patient. He recommends isolation.

DEATH CERTIFICATES BY UNQUALIFIED ASSISTANTS.

THE borough coroner for Hanley, on Jan. 29th, after an inquest on Mrs. Emma Harvey, who had been attended by Mr. Austerberry, Mr. Arthur Goodwin's unqualified assistant, who also filled up the death certificate in Mr. Goodwin's name, expressed his intention to report the circumstances to the General Medical Council. Mr. Goodwin had never seen the deceased. The registrars are showing a proper care in this serious matter. In this case the registrar, Mr. Hammersley, knowing that Mr. Goodwin was ill, scrutinised the signature, and found it was not in his handwriting. We trust Mr. Goodwin will be able to show that he was in no way responsible for this action of his assistant. It is amazing, after all that has happened in similar cases, that unqualified assistants should still be found to run such risks.

POISONING BY HYOSCINE.

DR. ADLER of Breslau publishes particulars of a case of poisoning by hyoscine. A man employed in the chemical laboratory used a glass for drinking purposes which contained a deposit of hydrochlorate of hyoscine. In a quarter of an hour he was attacked with vertigo, and gradually became unconscious. An hour and a quarter after taking the poison he was seized with convulsions, and rapidly became comatose. Upon arrival at the hospital he was found to be suffering from trismus, with occasional clonic spasm of the muscles of the lower jaw and of the limbs. The stomach was washed out, but no traces of hyoscine were found in the fluid withdrawn. Two centigrammes of morphia were immediately given hypodermically, after which the convulsions ceased, but the rigidity lasted until five o'clock in the evening. A hypodermic injection of one centigramme of pilocarpine was then given, but the effect of it was not apparent until three o'clock next morning, when the coma had given way to a drowsy condition and the pulse had dropped to 104. At 5 A.M. the patient was able to answer questions. He, however, became extremely rest-

less and excited. He was put under the effect of chloroform, and in a quarter of an hour he slept quietly. On waking he complained of great weakness, his gait was uncertain, and his pupils widely dilated. His urine contained hyoscine. He eventually entirely recovered.

ROYAL COMMISSION ON TUBERCULOSIS.

A MEETING of this Commission was held at 7, Whitehall-place, on Feb. 28th. Lord Basing occupied the chair, and there were present Professor Brown, Dr. Buchanan, Dr. Payne, Professor Burdon-Sanderson, and Mr. Leopold Hudson (secretary). The directors of the experimental investigations which are being undertaken as to the infectivity of tubercle and the ability of cooking processes to destroy such power of infection presented progress reports, and the results to date of the various inquiries which are being conducted were considered.

EFFECT OF ALKALIES ON METABOLIC CHANGE.

AS the effect of alkaline drugs upon the nature of the metabolic changes which albumen undergoes in the system has not been satisfactorily worked out, Dr. Yavein has made a series of elaborate observations on the subject, employing citrate and carbonate of soda for the purpose. The daily quantities of the drugs administered were 300 grains or more. The results showed as a rule that there was but little effect either on the assimilation or on the metabolic change of albumen. There was, however, a considerable increase in the neutral phosphates as compared with the acid phosphates of the urine. As a rule, the loss from the skin and lungs was diminished, and after the alkali had been discontinued the quantity of urine increased. The body weight increased while the alkali was being taken, and decreased afterwards, the increase being probably due to the diminished loss of moisture, and the decrease to the augmented secretion.

A CASE OF POISONING BY PILOCARPINE.

A BELGIAN OFFICER with an affection of the eyes was treated by the injection of two centigrammes of this drug. Immediately his neck and then the whole of the body became bathed with sweat, in two or three minutes he was salivated, and suffered from cardiac oppression and difficulty of breathing, he fancied his chest was full of fluid, and afterwards he expectorated some frothy mucus. The cardiac oppression lasted about ten minutes, but for two hours the patient continued to have a feeling of constriction at the pit of the stomach. During this time he suffered from lacrymation, running from the nose, gastralgia, and nausea; he vomited three times, and passed his urine involuntarily. The intestinal peristalsis became violent and he had tenesmus. His eyes were fixed, and he could not recognise anyone twenty centimetres distant. The pulse was quick and small, the sufferer being in a condition bordering on collapse. By means of internal and external stimulants the symptoms disappeared.

INFLUENZA IN HAMPSTEAD.

AN opportune report on the epidemic of influenza has been issued by Dr. Gwynn, the medical officer of health for Hampstead. In it he refers to the fact that the fatality as yet attributed to that disease has not nearly reached the point attained by the epidemic in the spring of 1891; and as regards London generally, he reminds us that the week in which the death-rate rose to its highest contributed only thirty-seven deaths registered as due to influenza, the actual deaths rising in four weeks from nineteen to 271, whereas in the same period the lowest number of deaths from whooping-cough was ninety-three, with a subsequent rise to 180, and this without exciting much comment. This bears out our remarks of last week with regard to the relation between the deaths from influenza and measles respectively. In the end, Dr. Gwynn advises that panic should be avoided, and he considers that it would be undesirable to deal with influenza as a dangerous infectious disease for the purposes of notification. In this we agree with him. The clinical features of the disease cannot be sufficiently differentiated from a number of other ailments, some of a comparatively trivial character, to justify any proceedings for non-compliance with the Act, and so long as this is the case it can hardly be right to bring it within the scope of a penal statute. At the same time Dr. Gwynn issues some useful suggestions as to precautionary measures which it is desirable to adopt.

SIR GEORGE PAGET, K.C.B., M.D., F.R.S.

BY the death from influenza of Sir George Paget on Friday, Jan. 29th, the University of Cambridge suffers a grievous loss. Born on Dec. 22nd, 1809, he entered as a student in the year 1827 at Gonville and Caius College, and in 1838 was created a Doctor of Medicine. In the year following he was elected a Fellow of the Royal College of Physicians. In 1869 he became President of the General Medical Council in succession to the late Sir George Burrows, and in 1872 the appointment of Regius Professor of Physic, vacant by the death of Dr. Bond, was conferred by the Crown on Dr. Paget. With his appointment the medical school at Cambridge began to rise in estimation and its degrees in worth, a change attributable to the perseverance and energy of Sir George Paget and of Sir George Humphry. He was an indefatigable worker. His bust adorns the meeting room of the General Medical Council. In 1886 he was created a K.C.B. His punctuality, charming manner, extensive experience, and skill endeared him to all with whom he was brought in contact. We reserve a detailed account of his labours for our next issue.

SMALL-POX OCCURRENCES.

SMALL-POX is somewhat prevalent in several northern districts. In addition to the prevalence at Batley, to which we have previously adverted, ten cases have been admitted to the Liverpool small-pox hospital; a case from Morley has been received into the Leeds isolation hospital; and several cases have occurred at Wakefield, where a magistrate's order was obtained to remove some cases to hospital, including a convalescent, and to prevent the sale of milk and butter from the premises in question.

DEFLECTIONS OF THE NASAL SEPTUM.

IN a paper recently read before the British Laryngological Society Mr. Mayo Collier very strongly contended, and his contentions were received with unanimous approval, that deflections of the nasal septum were almost always due to a difference in pressure on one side of the nasal septum, due to the blocking of one nostril, and to consequent aspiration of the closed cavity by the stream of air passing through the naso pharynx from the open one. From the examination of over 1000 living subjects 90 per cent. showed some deflection or other irregularity of the nasal septum; savages and aborigines only to the extent of 20 per cent.; children under ten years not at all; but from ten to sixteen blocking and consequent deflection were most easily induced from the more frequent occurrence of injury to the small dilators of the nose, and their consequent paresis or paralysis.

FOREIGN UNIVERSITY INTELLIGENCE.

Geneva.—Dr. Frœlich has been recognised as *privat-docent* in Ophthalmology.

Gratz.—Professor J. Kratter of Innsbruck has been

appointed to succeed Professor Schauenstein in the Chair of Forensic Medicine. He has published several researches in hygiene, toxicology, and medical jurisprudence.

Montpelier.—Dr. Carrieu, Professor of Internal Pathology, has been appointed Professor of Clinical Medicine.

Naples.—The University has been closed for the present by the Minister of Education in consequence of a disturbance created by some of the students. This does not seem to have been perpetrated by medical students, though they have to bear the punishment as well as their colleagues. A strict inquiry is being made by Government officials.

St. Petersburg (Military Medico-Chirurgical Academy).—Dr. Favitski has been recognised as *privat-docent* in Medicine, and Dr. Batuïeff as *privat-docent* in Anatomy.

WE are asked to state that it has been arranged to hold an evening class in Public Hygiene at King's College, to commence on Tuesday next at 8 P.M., and to be continued on Fridays and Tuesdays at the same hour. It has been thought that this step, which is, it is said, the first of its kind attempted in London, will be likely to meet the convenience of many medical practitioners who are unable to attend classes in the daytime.

THE managers of the Metropolitan Asylums Board have determined, with the sanction of the Local Government Board, to place the Ambulance Service at the disposal of the public for influenza patients, for their removal to places other than the hospitals of the Board. The charge for the hire of the ambulance, including, when the patient is over ten years of age, the services of a male attendant, is 5*s*.

THE committee of organisation of the International Congress of Gynæcology and Obstetrics, which will hold its first meeting at Brussels in September, have elected Dr. Benington, of Newcastle-upon-Tyne, as Assistant English Secretary to act for the North-east of England.

WE regret to notice the death of Mr. William Adams, F.R.C.S., J.P., of Regent's Park. Mr. Adams was well known in the metropolis, and not infrequently attended the meetings of the Clinical and Pathological Societies, of which he had long been a member.

THE FRENCH GOVERNMENT SANITARY BILL.

IT has already been announced that M. Constans, Minister of the Interior, on behalf of the French Government has introduced in the National Assembly the project of a sanitary law. We have now before us the text of this Bill, and must confess that it seems a somewhat raw measure, which will require considerable improvement before it can be considered as completely satisfactory. Nevertheless, it is encouraging to see the French Government take the initiative in this matter, and some of the provisions of the Bill are excellent. Article 1 stipulates that when a commune is in need of sanitary works, or has not a sufficient supply of good potable water, the prefect shall invite the Departmental Council of Hygiene to deliberate and report on the nature of the sanitary works required. If the report does not agree that such works should be undertaken, it shall be forwarded to the Minister of the Interior, who, if he thinks it necessary, shall submit the matter to the Consulting Committee of Hygiene for France. If either the County Council of Hygiene or the National Consulting Committee of Hygiene decide that such sanitary works must be undertaken, then the prefect shall order the commune to carry out these measures. If such works are not commenced within three months, then they shall be taken in hand by the Government, though the commune will have to pay the entire cost, according to the law of Sept. 16th, 1807. At present the mayors of communes theoretically possess very extensive powers, but practically they dare not exercise these powers unless it be under the stress of some great epidemic. Now, however, it is proposed to give both the provincial authorities, and then the national or central government, the right to interfere, and bring the necessary pressure to bear on each locality. In other words, the object of the Bill will be to give the State the right to stimulate the local authorities who are unmindful or ignorant with respect to their duties. Article 2 of the Bill deals with domestic hygiene. When a house is considered unhealthy the mayor must call upon the local commission of hygiene to report and suggest the necessary improvements. If the report is opposed to any measures being taken, the mayor shall refer the matter to the higher authorities—i.e., the prefect or the Departmental Council of Hygiene. If either of these superior authorities approve, the mayor shall call upon the householder or the tenant to commence within eight days the necessary alterations. But there follow clauses by which appeals can be made against such decisions, though these appeals will be less expensive and more expeditiously settled than under the present laws. There is also a clause by which, if it is thought impossible to render a house wholesome, it may be closed by the mayor and declared unfit for habitation. Article 3 deals with insanitary areas, giving the communes the right of compulsory purchase, demolition, and reconstruction of such districts. Article 4 stipulates that no building can be erected unless the mayor approves of the system of drainage proposed; and no such new building can be inhabited till the local sanitary authority has viewed and approved the work done. Articles 5 and 6 deal with the contamination of water-supply, the surveillance of cesspools, &c., and Article 7 imposes the obligatory declaration of all cases of infectious disease within twenty-four hours. The declaration is to be made by the doctor or the midwife; and, in default of either, by the relatives or those in charge of the sick person. Article 8 will establish for the first time in France obligatory vaccination, and this not only for infants, but it also enforces revaccination at the tenth and at the twenty-first years. Articles 9 and 10 deal with the drawing up of a code of rules in each district for the prevention of disease. The following articles of the project describe the constitution and duties of the local and central committees or councils of hygiene, and the last—that is, the 18th—article abrogates the law of April 13th, 1850, and all other previous laws which are in oppositon to the present project. This last clause is most important. It is because the Belgian law is the same as the French law, minus the law of 1850, that such notable sanitary improvements have been successfully accomplished in Belgium, and especially in Brussels.

The Bill, it will be seen, is very short, and it seems extraordinary to provide for the sanitary legislation of a large country in eighteen articles. Among the many omissions we note the absence of any machinery for sanitary inspection. There are no clauses establishing medical officers of health, inspectors of nuisances, and surveyors. There are sanitary committees who may discuss cases submitted to them, but where are the functionaries to ferret out such cases? A committee of hygiene consists of doctors, chemists, engineers, architects, and notable and eminent inhabitants of the district, who are supposed to possess special knowledge of subjects relating to public health. These gentlemen will occasionally afford an hour or two to meet and discuss. As a sort of controlling committee, and more especially as a means of educating public opinion in matters of hygiene, they are very useful. But something more than this is urgently required. There must be medical officers and inspectors, whose sole business it shall be to work out the sanitary regeneration of the country.

PRESENTATION.—Mr. J. Harley Gough, L.R.C.P. Lond., M.R.C.S., has been presented with a case of surgical instruments by the nursing staff of the Royal Albert Hospital, Devonport, on resigning his appointment of resident medical officer, which he had held for upwards of two years.

THE EDINBURGH ASSOCIATION FOR THE REFORM OF MEDICAL EDUCATION.

PUBLIC MEETING IN EDINBURGH.

A PUBLIC MEETING of medical men and graduates interested in the reform of medical education was held on Monday last, Feb. 1st, under the auspices of the Edinburgh Association for the Reform of Medical Education. There was a large attendance of medical men resident in the city, more especially of the younger men, who are very earnest in their wish to see decided and radical improvement in the present methods of teaching. The chair was occupied by Lord Provost Russell, who is himself a graduate in medicine of Edinburgh, and was at one time a demonstrator of anatomy in the University, and is *ex officio* a member of the University Court. In his opening remarks he referred to the high position the University had attained, and to the fact that the citizens and the people of Scotland were proud of it. To maintain its high position it was necessary that it should advance with the times, and it was the recognition that such advance was necessary, and was not sufficiently provided for in the Draft Ordinances of the Commission, that the Association was called into existence. Changes in the methods of teaching and reforms very often meant alterations that apparently affected vested interests; but he thought it was quite possible to discuss such changes without making it appear that any injury was intended by changes proposed to be introduced at the instance of the Association.

Dr. Batty Tuke moved the first resolution, which was as follows: "That this meeting deems it essential that the Commissioners should insist on a diminution in the number of systematic lectures with a view to make room for practical work and demonstrations to limited numbers of students." In his speech supporting this motion he considered the causes which had led to the success of the University, and pointed out that the London schools had only recently realised the true cause of Edinburgh's success. One of the mainstays of Edinburgh University was the extreme conscientiousness and the perfect thoroughness with which their hospital men performed their work. He would challenge any school in Great Britain or abroad to produce active, busy, professional men devoting two or three hours a day to the education of the students in the hospital. He thought it would be admitted that practical teaching was essential to the educational spirit of the age, and their Association held that the practical system should be extended and the systematic lectures reduced. They were not the first to advocate this reform, for it was laid down by the General Medical Council of Education and Registration in a series of resolutions which were adopted in 1880. Practical teaching necessitated smaller classes, and this in turn necessitated a greater number of teachers.

Dr. C. W. Cathcart seconded the resolution, which was carried unanimously.

Principal Grant Ogilvie proposed the second resolution: "That an 'honours' school should be established, in which the more capable students may undergo a more extended training and present themselves for special honours examinations."

This resolution was seconded by Dr. Berry Haycraft, who pointed out that if the present ordinance of the Commissioners was retained they would be tied up for the next thirty years or more to a regulation curriculum and examination system through which good, bad, and indifferent students had alike to pass, and from which they would be turned out as so many machine-made articles. If in the future their Simpsons, Symes, Bruntons, and Ferriers were to be produced by English schools, they must give up the hope of keeping their University in the front rank of teaching institutions, and the loss of prestige would react on the mass of students. The way to avoid this was by arranging for a limited number of capable and ambitious men, and an extended and elastic curriculum, as complete, or more so, as any obtainable in the best English or foreign school.

This motion led to a good deal of discussion, which was introduced by Dr. Byrom Bramwell taking exception to the suggestion that for honours it would be necessary to go right through the whole special curriculum sketched for the honours school, and that a modification of the present system was more desirable. At the same time, he in other respects heartily agreed with the proposals of the Association, and held that the recommendations and alterations in the draft ordinance were altogether ineffectual and insufficient for the requirements of the case. His amendment was as follows: "That it is undesirable to interfere with the present system of giving honours, with the exception that the work required for the ordinary pass examination should in each subject be limited and defined by printed syllabus, an additional question or questions, not necessarily included in those portions of the subject specified in the pass examination syllabus, being added in each written paper for honours candidates, and the extent and severity of the *viva voce* and practical portions of the examination being, in the case of honours candidates, proportionately increased." Drs. McBride, Joseph Bell, William Russell, and Hoernlé took part in the discussion, and favoured the proposals of the Association, and on being put to the vote the original motion was carried by a large majority.

The third motion was submitted by Dr. G. A. Gibson: "That the meeting would strongly urge the necessity for allotting the last two years of study to the systematic and clinical work of the final subjects and specialties." This was seconded by Dr. Berry Hart. Both mover and seconder spoke strongly on the necessity of this, both from the student's standpoint and the public necessity of having men thoroughly trained in the practical study of disease. They also animadverted on the carrying on of materia medica and pathology to the end of the fourth year. This motion was also unanimously carried.

The last motion was proposed by Dr. G. A. Berry and seconded by Dr. Cadell, and bore upon the necessity of increasing the number of examiners, so as to give ample time for testing students' knowledge.

The meeting was altogether a very successful one, and the report of it which has appeared in the newspaper press has aroused very general interest throughout the city.

ARMY MEDICAL SCHOOL, NETLEY.

THE sixty-third (winter) session of this School was brought to a close on Monday, when the distribution of prizes took place, General Sir Frederick FitzWygram, Bart., M.P. for the Fareham Division of Hants, performing the interesting ceremony. The proceedings were carried out in the lecture theatre of the Royal Victoria Hospital, in the presence of a numerous gathering of ladies and of military and medical officers, including Surgeon-Major-General Lithgow, D.S.O., Surgeon-Major-General Tippetts, P.M.O. at Netley, Sir Joseph Fayrer, K.C.S.I., Professor Sir William Aitken, F.R.S., Professor J. Lane Notter, Surgeon-General W. C. Maclean, C.B., the assistant professors, Messrs. Bruce, Davies, Stevenson, and Whitehead, and the secretary of the School, Mr. Bouchert. There were also present Colonel Hanning Lee, Major Haldane, Major Stoke, Captain Attree, R.E., Acting-Adjutant Surgeon-Captain C. J. Addison, M.S. (by whom the surgeons on probation of both the Army Medical Service and the Indian Medical Service were marched up to the lecture theatre), Colonel the Hon. H. G. L. Crichton and Lady Emma Crichton, Lady Aitken, Mr. Bloxam, Mrs. Godwin, Mrs. Notter, Mrs. and the Misses Cayley, Mrs. Hayes, Miss Erskine, Mrs. Bruce, Mrs. Du Chaumont, Mrs. Davies, Miss Norman (lady superintendent of nurses), and a few of the nursing sisters.

Sir Frederick FitzWygram, after handing the prizes to the successful students, said that all medical charges were important and responsible, but none were more important or responsible than those of the medical officers of the army. In fact, he might say he knew of no medical charges so important or responsible, because in military medical life, especially abroad and in war, they would have to lean entirely on their own knowledge, skill, and practice. In civil life it was otherwise. In civil life, according to their aptitude and circumstances, they generally drifted into one particular line, and adopted surgery, medicine, or some special subject. But in the army they needed medical men who were well up in every branch of the best modern medical science. They needed, if he might use the expression, all-round men—a military medical officer who was

at once surgeon, physician, accoucheur, oculist, aurist, chemist, analyst, an expert in sanitary science, and, almost above all, a good nurse; one who could not only teach those under him, but who possessed the delicate art of ministering to the wants of the suffering. They needed the best and brightest students of their schools, and he hoped many of those he saw would well sustain, and, it might be, increase, the best traditions of the honour and skill of the Army Medical Department.

Sir Joseph Fayrer said it gave him renewed pleasure to come year after year and see the fresh young faces of those about to enter a new sphere of life.

Mr. Bloxam, one of the surgeons of Charing-cross Hospital, London, who twenty-five years ago was a student at Netley, expressed a wish, in his concluding remarks, that there were opportunities for surgeons after passing to come back to Netley for another course of work.

Sir Frederick FitzWygram referred to the matter touched upon by Mr. Bloxam. Medical officers when going on foreign service naturally lost touch with some matters, and he had suggested that on their return they should be allowed six months, on full pay, to study at one of the great hospitals. He thought if the heads of the department would follow up that idea there would be no difficulty in getting it carried out, and the plan would be of immense advantage.

INFLUENZA.

THERE can be, happily, no question that the epidemic of influenza is at length subsiding in this country, and although it still prevails with considerable severity in some districts, we do not hear of its extension to districts which have hitherto escaped; whilst the cases are diminishing in several counties that have been particularly attacked. The mortality returns for the week ending Jan. 30th substantiate this, for although next to Croydon (47·2 per 1000), London heads the list with an estimated death-rate of 41, yet the deaths directly attributed to influenza in the metropolis have fallen from 506 to 436, in addition to which there were 71 cases in which influenza was noted as a secondary cause. This may seem a slight decline, but we have little doubt that a much more marked fall will be recorded next week. There has *pari passu* been a decline in the number of deaths from respiratory diseases—viz., from 1465 to 1192, but the latter is 654 in excess of the corrected average. Brighton, we are glad to see, is rapidly recovering its normal death-rate, the returns showing the remarkable decline from a rate of 60·9 in the preceding week to one of 24·6. Indeed, the death-rate is lower this week in most of the thirty-three large towns quoted by the Registrar-General; but it still remains abnormally high in Norwich (39·1), Blackburn (37·5), Birkenhead (34·0), and Liverpool (33·1).

Accounts of the subsidence of the epidemic come from South Kent, Surrey, Hants, and North Wilts, but there does not as yet appear to be any marked diminution in Essex, Norfolk, Northamptonshire, and Yorkshire.

On the Continent, it still prevails to a considerable extent in some parts of Germany, especially in Mecklenburg, and in Vienna it is said to be "alarmingly on the increase."

METROPOLITAN HOSPITAL SUNDAY FUND.

ARCHDEACON SINCLAIR presided at a meeting of the members of the Council of this Fund, held at the Mansion House on Tuesday last. The Lord Mayor was unavoidably absent. Mr. H. N. Custance, the secretary, announced anonymous donations of £500 and £50 respectively. Allusion was made to the loss by death of Sir J. Risdon Bennett and Cardinal Manning, who were valued members of the Council. The Chief Rabbi, Lord Sandhurst, Mr. Wakley, Mr. A. L. Cohen, Dr. Charles J. Hare, and Canon Ingram were elected to serve on the General Purposes Committee, in the place of several members who had died or who were unable to attend the meetings. Mr. H. C. Burdett moved the adoption of a uniform system of accounts for hospitals and dispensaries. The system proposed would, he said, be a great advantage, and it had been agreed to by secretaries of the hospitals and dispensaries interested in the Fund. Dr. Glover seconded the motion, and it was carried on the understanding that a suggestion by Mr. Acland, chairman of the Hospital Saturday Fund, to the effect that items should be separately put in the income accounts, showing the amount derived from workshop contributions and church parades, should be further considered.

Dr. J. H. Rigg moved, and the Chief Rabbi seconded, a vote of condolence to the widow of Mr. Spurgeon, who had frequently preached earnestly on behalf of the Fund. The vote was unanimously passed.

VITAL STATISTICS.

HEALTH OF ENGLISH TOWNS.

IN thirty-three of the largest English towns 6227 births and 6275 deaths were registered during the week ending Jan. 30th. The annual rate of mortality in these towns, which had increased in the preceding three weeks from 28·7 to 35·4 per 1000, declined again last week to 32·1. In London the rate was as high as 41·0 per 1000, while it averaged 25·7 in the thirty-two provincial towns. The lowest rates in these towns last week were 18·4 in Sunderland, 19·2 in Halifax, 19·5 in Salford, and 19·8 in Birmingham; the highest rates were 34·0 in Birkenhead, 37·5 in Blackburn, 39·1 in Norwich, 41·0 in London, and 47·2 in Croydon. The 6275 deaths included 455 which were referred to the principal zymotic diseases, against 604 and 518 in the preceding two weeks; of these, 241 resulted from whooping-cough, 92 from measles, 39 from diphtheria, 34 from diarrhœa, 25 from "fever" (principally enteric), 24 from scarlet fever, and not one from small-pox. No fatal case of any of these diseases was recorded in Croydon, Brighton, Plymouth, Huddersfield, or Halifax, while they caused the highest rates in Swansea, Wolverhampton, Derby, and Blackburn. The greatest mortality from measles occurred in Derby, Newcastle-upon-Tyne, Wolverhampton, and Burnley; from scarlet fever in Cardiff and Swansea; from whooping-cough in West Ham, Swansea, Bolton, London, Bristol, Wolverhampton, and Derby; from "fever" in Blackburn; and from diarrhœa in Preston. The 39 deaths from diphtheria included 24 in London, 3 in Salford, 2 in Manchester, and 2 in Bristol. No fatal case of small-pox was registered in any of the thirty-three great towns; 7 small-pox patients were under treatment in the Metropolitan Asylum Hospitals, and 2 in the Highgate Small-pox Hospital. The number of scarlet fever patients in the Metropolitan Asylum Hospitals and in the London Fever Hospital at the end of the week was 1327, against 1391 and 1397 at the end of the preceding two weeks; 100 new cases were admitted during the week, against 92 and 116 in the previous two weeks. The deaths referred to diseases of the respiratory organs in London, which had been 1084, 1248, and 1465 in the preceding three weeks, declined last week to 1192, but exceeded by as many as 654 the corrected average. The causes of 94, or 1·5 per cent., of the deaths in the thirty-three towns were not certified either by a registered medical practitioner or by a coroner. All the causes of death were duly certified in Portsmouth, Norwich, Preston, Newcastle-upon-Tyne, and in six other smaller towns; the largest proportions of uncertified deaths were registered in Oldham, Blackburn, Sheffield, and Hull.

HEALTH OF SCOTCH TOWNS.

The annual rate of mortality in the eight Scotch towns, which had been 23·9 and 27·2 per 1000 in the preceding two weeks, declined again to 24·7 during the week ending Jan. 30th, and was as much as 7·4 below the mean rate during the same period in the thirty-three large English towns. The rates in the eight Scotch towns ranged from 19·0 in Greenock and 19·1 in Paisley to 26·0 in Glasgow and in Leith and 30·2 in Aberdeen. The 687 deaths in these towns included 16 which were referred to whooping-cough, 7 to "fever," 6 to measles, 6 to diarrhœa, 4 to diphtheria, 2 to scarlet fever, and not one to small-pox. In all, 41 deaths resulted from these principal zymotic diseases, against 50 and 72 in the preceding two

weeks. These 41 deaths were equal to an annual rate of 1·5 per 1000, which was 0·8 below the mean rate last week from the same diseases in the thirty-three English towns. The fatal cases of whooping-cough, which had been 16 and 24 in the preceding two weeks, declined again to 16 last week, of which 6 occurred in Aberdeen and 5 in Glasgow. The deaths referred to different forms of "fever," which had been 6 and 5 in the previous two weeks, rose to 7 last week, and included 4 in Glasgow. The 6 fatal cases of measles showed a decline of 5 from the number in the preceding week, and included 5 in Glasgow. The deaths from diphtheria, which had been 5 and 9 in the previous two weeks, declined again to 4 last week, of which 2 occurred in Glasgow and 1 each in Leith and Greenock. The 2 fatal cases of scarlet fever were considerably below those recorded in any recent week, and included 1 in Aberdeen and 1 in Paisley. The deaths referred to diseases of the respiratory organs in these towns, which had increased in the preceding three weeks from 200 to 230, declined again last week to 211, and were within 4 of the number in the corresponding week of last year. The causes of 69, or nearly 10 per cent., of the deaths in the eight towns last week were not certified.

HEALTH OF DUBLIN.

The death-rate in Dublin, which had increased in the preceding three weeks from 35·0 to 54·1 per 1000, declined again to 41·5 during the week ending Jan. 30th. During the first four weeks of the current quarter the death-rate in the city has averaged 43·6 per 1000, against 40·0 in London and 22·2 in Edinburgh. The 278 deaths in Dublin during the week under notice showed a decline of 85 from the exceptionally high number in the preceding week, and included 5 which were referred to whooping-cough, 3 to "fever," 1 to diarrhœa, and not one either to small-pox, measles, scarlet fever, or diphtheria. In all, 9 deaths resulted from these principal zymotic diseases, equal to an annual rate of 1·3 per 1000, the rate during the same period being 3·2 in London and 0·8 in Edinburgh. The fatal cases of whooping-cough, which had been 5 and 10 in the preceding two weeks, declined again to 5 last week. The deaths referred to different forms of "fever," which had been 2 and 5 in the previous two weeks, declined to 3 last week. The 278 deaths registered in Dublin last week included 32 of infants under one year of age, and 105 of persons aged upwards of sixty years; the deaths both of infants and of elderly persons showed a marked decline from the very high numbers recorded in the preceding week. Four inquest cases and 5 deaths from violence were registered; and 80, or more than a fourth, of the deaths occurred in public institutions. The causes of 26, or more than 9 per cent., of the deaths in the city last week were not certified.

CALCUTTA AND ITS SUBURBS.

We learn from the memorandum published by Dr. W. J. Simpson, the health officer of Calcutta, in connexion with the vital statistics of that city and its amalgamated area of suburbs, that the total number of births registered in Calcutta in September last was 693, giving an annual ratio of 17·8 per 1000 of population. The total deaths registered during the month were 1041, showing an annual ratio of 26·7 per 1000 The proportion of male to female deaths was as 158 to 100. The monthly total exceeds the corresponding figures of the past decade, and surpasses the decennial mean by 171. There were 82 deaths from cholera, against 29 in the preceding month. No deaths from small-pox. There were 124 deaths from bowel complaints, against 83 in the preceding month. From tetanus there were 80 deaths, against 64 in the preceding month; of these, 74 were under one year of age. The total mortality of infants under one year, reckoned on estimated births, was 342·9 per 1000 of population. In the amalgamated area of suburbs 326 births were registered during September, giving an annual ratio of 18·1 per 1000. The total number of deaths registered was 603, against 525 in the preceding month, giving an annual ratio of 33·6 per 1000. Of these deaths, 23 were from cholera, 270 from fevers, 89 from bowel complaints, and 56 from tetanus. In the tables of comparative mortality in cities of Bengal, Bombay, Madras, North-Western Provinces, and the Punjab having more than 50,000 inhabitants, we notice that in Madras, from Aug. 15th to Sept. 11th, 1891, the annual death-rate amounted to 105·2 per 1000. At Cawnpore it was 55·2 for July, 49·5 for Delhi, 40·7 for Lahore, and 51·0 for Peswar for the week ending June 27th last. According to the latest return, that for the week ending Dec. 5th, 1891, the birth-rate at Calcutta was rather higher than the corresponding week of last year. There were 46 deaths from cholera, none from small-pox. The general annual death-rate was 39·7, against 32·4 per 1000, the mean of the last five years. In the amalgamated area of suburbs, the deaths (177) were lower during the week than in the corresponding week of the previous year: 21 deaths from cholera; none from small-pox. The death-rate of the week was 42·9 per 1000 of population. The general death-rate of the combined area is equal to 40·7 per 1000.

THE SERVICES.

PROMOTION IN THE INDIAN MEDICAL SERVICE.

The Times of India, of Jan. 16th, 1892, publishes the following:—"A question arose some time ago as to whether Brigade Surgeons of the Indian Medical Service could decline promotion to the rank of Deputy Surgeon-General. Medical officers holding lucrative civil appointments were disinclined to leave their posts when their turn came for military promotion, preferring to abandon their claim to higher rank. It has now been ruled that if, after considering all circumstances affecting any particular case, Government deem it expedient in the interests of the public service to nominate a Brigade Surgeon for promotion, that officer is not to be given the option of refusing it."

The death is reported of Brigade Surgeon S. P. White from pneumonia after influenza. He had retired in 1888, after twenty-eight years' service. The deceased was with the expedition against the Hazara tribes in 1868, during the Afghan War, the capture of Urzoo, and the engagements near Ghanzi.

Brigade Surgeon-Lieutenant-Colonel Samuel Maunsell died on Dec. 31st, 1891, at the West Indies. Lieutenant-Colonel Maunsell was a son of the late Rev. Thos. Maunsell, of Balnagarnon House, Fintona, County Tyrone.

Surgeon-Major Forbes Dick, M.D., Medical Staff, died on the 25th inst. at Queen-square, Lancaster, aged fifty. He became assistant-surgeon in the Army in September, 1863, surgeon in March, 1873, surgeon-major in April, 1876, and retired on half-pay in October, 1888.

ARMY MEDICAL STAFF.—Surgeon-Major-General Sir James Arthur Hanbury, M.B., F.R.C.S.I., K.C.B., is placed on retired pay (dated Jan. 13th, 1892); Surgeon-Lieutenant-Colonel John Godfrey Rogers, M.B., D.S.O., retires on retired pay (dated Feb. 3rd, 1891).

NAVAL MEDICAL SERVICE.—The following appointments have been made at the Admiralty:—Surgeons: Graham E Kennedy to the *Defiance* (dated Feb. 13th, 1892); Jerome Barry, M.D., to the *Ganges* (dated Feb. 16th, 1892); John Andrews, M.D., to the *Dart*, and Edward C. Cridland, M.B., to the *Paluma* (both dated Feb. 4th, 1892).

VOLUNTEER CORPS.—*Artillery:* 1st Forfarshire: William James Peddie, M.B., to be Surgeon-Lieutenant (dated Jan. 30th, 1892)—1st Cumberland: Surgeon-Major J. A. Macdougall resigns his commission; also is permitted to retain his rank, and to continue to wear the uniform of the Corps on his retirement (dated Jan. 30th, 1892)—*Rifle:* 1st Surrey (South London): Charles Swaby Smith, Gent., to be Surgeon-Lieutenant (dated Jan. 9th, 1892)—3rd Volunteer Battalion, the Duke of Wellington's (West Riding Regiment): Richard Ernest Williamson, M.B., to be Surgeon-Lieutenant (dated Jan. 30th, 1892).—2nd Volunteer Battalion, the Duke of Cambridge's Own (Middlesex Regiment): Surgeon-Major C. A. Patten to be Surgeon-Lieutenant-Colonel (dated Jan. 30th, 1892)—2nd (South) Middlesex: Surgeon-Major T. Trent resigns his commission; also is permitted to retain his rank, and to continue to wear the uniform of the Corps on his retirement (dated Jan. 30th, 1892).

ROYAL INSTITUTION.—Professor E. Ray Lankester, F.R.S., will, on Thursday next, Feb. 11th, begin a course of three lectures on "Recent Biological Discoveries;" and the Right Hon. Lord Rayleigh, F.R.S., will, on Saturday, Feb. 13th, begin a course of six lectures on "Matter: in Rest and in Motion."

Correspondence.

"Audi alteram partem."

THE ROYAL COLLEGE OF SURGEONS AND THE ASSOCIATION OF MEMBERS.

To the Editors of THE LANCET.

SIRS,—Your leader on the proceedings in the High Court of Law (Chancery Division) last week in the action Steele *v.* Savory, which ended so disastrously for the Association of Members, will have been seriously pondered over by all concerned. Many, no doubt, will be asking themselves, What next? What is the probable bearing of Mr. Justice Romer's decision on the Association and on the larger question bearing on the "abstract right to a share in the administration of the College"? Possibly the majority will think "sufficient for the day is the evil thereof." So be it; but there is just a point or two so far, to which I should like to draw particular attention. First, it will appear to most of us that the validity or otherwise of By-law xvii. is scarcely worth further contention, certainly not in a court of law; as, come what may, there will be no further attempt to defy the Council on this question. That being so, there remains the larger contention, "the measure of the rights of the Members of the College," which has been the real bone of contention at the annual meetings since 1884. Now, it will scarcely be denied that this will be better met in the spirit you have foreshadowed, conciliation, and which will doubtless commend itself to all concerned, since, as you say, "it is a question upon which no court of law or of equity has jurisdiction to enter." This being so, the majority will see the advisability of at once acting upon so commendable a suggestion, "that both parties ..... resume the discussion with an enhanced desire to arrive at an agreement. [Most assuredly], if that could be effected, there seems to be no room for doubt that any settlement which might be adopted by consent would easily receive the necessary authorisation, and so acquire the force of law." May I, then, suggest that the Association of Members do forthwith appoint a deputation to wait upon the President and Council of the College, not simply to ascertain their views, but fully empowered to submit terms for the settlement of all matters in dispute? This course will, I believe, give the right turn to the discussion, tend to restore harmony between the Council and the Members, and put the final stop upon any further waste of money in useless litigation.

I remain, Sirs, yours truly,
ONE OF THE ASSOCIATION OF MEMBERS OF THE ROYAL COLLEGE OF SURGEONS.

Jan. 30th, 1892.

INFLUENZA.

To the Editors of THE LANCET.

SIRS,—Although the present epidemic shows signs of abatement so far as Stoke Newington and Hackney are concerned, I shall be glad if you will allow me a few remarks on the prevention and treatment of this troublesome scourge. For prevention the public seem to place most faith in ammoniated quinine, eucalyptus, tobacco, and whisky, the two latter especially commending themselves to many who are only too pleased to have some plausible excuse for indulging in their favourite weaknesses; but the fact that many victims of influenza were "protected" by one or all of these prophylactics is sufficient proof of their inefficacy. On the other hand, the suggestion of one of your correspondents some weeks ago as to the use of carbolic acid and glycerine in equal parts, a few drops to be placed on the handkerchief before leaving the bedroom each morning, is in my experience most valuable. I have largely recommended it, and so far as I know no one who has tried it has been affected. As regards treatment, the bicarbonate of potassium method seems to bear out much that Mr. Crerar contends for it; but in my opinion we have all the advantages, and none of the undoubtedly depressing disadvantages, of the bicarbonate in another drug, which is inexpensive (no slight consideration in practices where numerous club patients have to be provided with medicine), which alkalinises the blood but not the urine, which stimulates the cord and nervous system generally, and which is especially valuable in preventing, or when present mitigating, bronchitis and pneumonia, which as we all know are the complications from which we have most to fear. I refer to carbonate of ammonium. This drug in 5 gr. doses every four hours during the first stage I have largely used in the three outbreaks we have had, and patients declare that every dose gives relief to the pains. Besides this, if the case is seen at the outset I prescribe from 8 to 10 gr. of Dover's powder alone, or, in case of constipation, combined with from 2 to 3 gr. of calomel. In twenty-four to thirty-six hours the fever is subdued, the pains are relieved, the tongue cleans, appetite returns, and nux vomica rapidly restores the strength. For the troublesome but characteristic cough belladonna proves an efficient remedy. Salicylate of soda and antipyrin, or the new combination salipyrin, possess no advantages over carbonate of ammonium, and in some ways are distinctly its inferior.

I am, Sirs, yours faithfully,
WILLIAM WHITELAW, M. D.

Stoke Newington-road, N., Feb. 1st, 1892.

To the Editors of THE LANCET.

SIRS,—It may be worthy of remark, and in some measure may account for the great bound made in the apparent mortality from influenza in London during the past weeks, that a great difference is to be observed in the style of returning the death certificate by the certifying practitioner. At the commencement of an epidemic influenza is rarely returned as the primary cause, but is generally placed as a second or even third cause. During the further progress of the epidemic, when it has become much talked about, and, in a sense, fashionable, all this becomes reversed. We now find influenza returned as a primary cause, such complications as pneumonia and bronchitis being relegated to secondary positions. It even happens that chronic cases of diabetes, heart and kidney diseases, &c., are then returned as dying primarily of influenza; yet it must be obvious that these persons were, like ripe fruit, ready to fall from any disturbing cause, the influenza in these cases being but the proverbial "last straw." There is good reason for thinking, from the behaviour of influenza in previous epidemics, that we have reached the culminating point of the present epidemic, and may look for a period of decline. As most practitioners are finding themselves at present overworked, it may be some comfort to them to predict a period of general slackness during the ensuing summer months, such as was notoriously the case during the autumn months after the epidemic of 1891.

I am, Sirs, yours faithfully,
EDMUND GWYNN, M.D., M.O.H.

Vestry Hall, Hampstead, N.W., Feb. 1st, 1892.

To the Editors of THE LANCET.

SIRS,—I have just been reading in the daily press Dr. Parsons' very sensible suggestions with regard to the isolation and disinfection of cases of influenza, but I want to ask the question, Is it an infectious disease in the ordinary acceptation of the word? If yes, how is it we have none of it here at Monte Carlo, where all the means of spreading infectious disease are, so to speak, concentrated? Here in the Casino we have daily thousands of people from all quarters of the globe concentrated in a confined and artificially heated atmosphere; we have them all subjected to feelings of great excitement and great depression, the invariable accompaniments of gambling, and yet up to this date we have remained absolutely free from anything like an epidemic. I myself have seen only one case—a lady coming straight from America. She was taken ill on the journey, and I saw her immediately on her arrival. She was in a crowded hotel, and no precautions were taken. This was three weeks ago, and no other case has occurred in the hotel. A yacht came into the bay at Monaco, and I was asked to see a sailor on board who was ill. I found him suffering from well-marked influenza. This then ran through the whole crew. A strong wind sprung up, and the yacht had to be sent round to Villefranche (the Monaco bay not being a safe anchorage in stormy weather). The owner of the yacht then came on shore, and went to live in one of the largest hotels in the place. He also brought not a single germ of the disease to the other 200 people in the same hotel. I do not mean to assert for one moment that Monte Carlo will remain free from the epidemic for the

whole of this season, but I do most strongly feel that if it does come later on we must look to some other cause, atmospheric or otherwise, than infection in the ordinary acceptation of the word.

I am, Sirs, yours truly,

CHAS. F. HUTCHINSON, M.D.

Villa Mai, Monte Carlo, Jan. 27th, 1892.

To the Editors of THE LANCET.

SIRS,—I have treated during the last two years a very large number of cases of influenza, and have myself suffered from a severe attack of it. The more I have seen of the disease the more have I been convinced that there is no specific for it, and that there is no regular course of treatment suitable for any case. The disease manifests itself in a great variety of ways, and although it is undoubtedly of neurotic origin, yet the particular idiosyncrasy of the patient determines its variety: Antipyrin, phenacetin, salol, salicylate of soda, bicarbonate of potash, citrate of potash, and frequent drinking of abundance of hot water are all useful in cases suitable, but none of them can be styled "the best form of treatment." I have found that when the temperature was under 102° drinking plenteously of hot water, with a hot poultice over the kidneys, and frequent sponging of the limbs with hot water, was, with a warm bed and a comfortable room, a most satisfactory mode of treatment. I found in my own case the greatest relief from the sponging and the hot poultice over the loins. The disease is always of a most depressing character, and during convalescence is the time when the experience of the physician is most demanded, and where again it is impossible to lay down any fixed rule. Strychnine is the tonic most generally necessary; but here again particular symptoms must be considered. I think very great harm has resulted to the public from the advocacy of particular remedies, which have caused them to neglect the various details—generally the most essential thing to remember. The most important question is, When does the disease begin to be infectious and when does it cease to be so? I am, Sirs, yours truly,

JOHN R. HAMILTON, M.D. &c.

Hawick, N.B., Feb. 2nd, 1892.

To the Editors of THE LANCET.

SIRS,—Like Dr. Gordon Black of Harrogate, I have had lots of cases of influenza accompanied by rashes simulating scarlatina and measles, but those cases occur mostly, I think, in the young. I have a boy patient just now who is suffering undoubtedly from an influenzal attack, where the measly rash is so general and pronounced on his body that my assistant persists in calling it a case of measles. I have also had a fatal case of influenza complicated by endocarditis, where the roseolar rash on the woman's breast, arms, and legs was very bright, and where the face, hands, and feet were much puffed and perfectly livid. This patient died suddenly on the third day of my attendance. Perhaps our locality may have something to do in the causation of exanthematous forms of this scourge.

I am, Sirs, yours faithfully,

A. ROSS PATERSON, M.D. Aberd., M.R.C.P. Ed.

Stockton-on-Tees, Feb. 1st, 1892.

A CASE OF UNRECOGNISED CERVICAL CARIES.

To the Editors of THE LANCET.

SIRS,—The case described by Mr. Owen, and published in THE LANCET of Jan. 30th, should call more attention to the diagnosis of caries of the spine in adults. I can bear witness to the fact that such cases are frequently left unrecognised. During the last few months I have had four cases of this kind. No. 1 was a young lady aged twenty-one, in whom symptoms of nerve irritation in the arms, and some pain in the upper dorsal region of the spine, occurred, regarding which there was a difference of opinion, but which has since developed into unmistakable inflammation of the vertebræ. No. 2 was a youth aged eighteen (hardly an adult, but beyond the age of childhood), in whom there was caries in the lower cervical and upper dorsal vertebræ, with considerable deformity, but in consequence of implication of the heart and liver the former disease was overlooked, at least as a cause of the symptoms, and the latter was considered to be the origin of the great pain and illness. The case was considered hopeless at first, but by careful treatment of the spine the symptoms have gradually lessened, and there seems a good prospect of ultimate recovery. No. 3, a lady aged forty, who had been quite well until thirteen months before I saw her, when pains began in the left arm, extending to the right arm and to the upper part of the dorsal region of the spine. Treatment for rheumatism and general health, including seaside air, had failed to relieve the constant pain, and the patient could hardly move from one room to another. There was projection from the seventh cervical vertebra to the third dorsal, and the surrounding part was swollen and painful upon pressure. Suitable treatment relieved the pain, and after three months the patient has made considerable progress towards recovery. No. 4, a lady aged thirty-five, had had pain in the back of the neck for two years, with various symptoms of irritation of the cervical nerves, affecting the neck and arms. This case has been under treatment also nearly three months, pain ceasing almost entirely from the commencement of treatment, and the patient is gaining strength.

For the sake of brevity I have omitted details in describing these cases. With regard to treatment, I believe that mechanical fixation is the most important part. Recumbency in bed seldom, if ever, fixes the diseased parts perfectly. In recumbency alone, notwithstanding the use of sandbags, every movement of the body or the arms must disturb the diseased part, unless, indeed, the patient be fixed down tightly to the bedstead by the shoulders, the pelvis, and the abdomen. The latter proceeding would convert the bedstead into a splint, and it will be found that a carefully adapted mechanical apparatus controlling the spine and the head will be more supporting to the part, far less irksome to the patient, and more thoroughly adaptable by the surgeon to the requirements during the progress of the case.

I am, Sirs, yours faithfully,

Queen Anne-street, W., Feb. 1st, 1892. NOBLE SMITH.

NORTHERN COUNTIES NOTES.

(FROM OUR OWN CORRESPONDENT.)

The Notification of Measles in Newcastle.

AT a special meeting of the Corporation of the Newcastle Sanitary Committee, held last week, to take into consideration the notification of measles, a long and interesting discussion took place, and ultimately a vote was taken, the numbers for and against the notification of measles being equal. The chairman, however, declined to give his casting vote, in order that the matter might stand over for a short time for reconsideration. It is well known that our city officer of health holds strong views, which he has frequently expressed, as to the notification of this disease, which, he thinks, causes more loss of life than scarlet fever. I believe that the notification of measles will be conceded in a short time. At present the influenza is the all-absorbing topic of conversation; the public appear to be unable to think of more than one disease at a time, and whichever is foremost in their minds obscures all others. The notification of influenza was mooted the other night at the meeting of our Clinical Society, but the medical officer of health thought that as isolation was impracticable notification would be useless. Certainly the stage of incubation being for the most part so brief, it is not easy to see what good could accrue from notification, and it is well to avoid putting more burdens on our already patient profession.

Newcastle Lying-in Hospital.

The annual meeting of the governors of the Newcastle Lying-in Hospital was held last week. The report stated that 247 cases had been attended during the past year, and two deaths had occurred in the out-door department of the charity. The treasurer's statement showed a balance of £30, so that the hospital is now free from debt.

Carlisle.

It was mentioned at the board of guardians that influenza was somewhat abating, that the old people had been very severely attacked, and some of the cases were very bad ones. On one day last week there were 110 cases. The medical officer, in his annual report, states that scarlet

fever had been very prevalent during the year, 564 cases having been notified; but the death-rate for the year had not been more than 19 per 1000, allowing for some cases not belonging to the Carlisle urban sanitary district.

Criminal Law.

In the course of a lecture lately delivered at Carlisle by Dr. Lediard, he referred to the post-mortem examination of the dead, which, he said, should be watched in the prisoner's interests, apart from the prosecution. The various steps of dealing with the body or parts of the body should be watched in the prisoner's behalf. The organs as removed from the body should be noted and observed by a medical man engaged for the prisoner. The eye sees what it expects to see. A medical man was looking out for certain appearances, and his judgment might mislead him. Where money was at hand they found that prisoners' interests were invariably guarded in the manner described, and fallacies of observation and errors of judgment corrected at once with the happiest results. Dr. Lediard thought that a Court of Criminal Appeal should be as easy of access to the poor as the rich. Upon the whole, he favours the Scotch system in criminal procedure, where the procurator fiscal takes action, instead of, as with us on this side of the Border, the police.

High Rate of Mortality at Annan.

At the border town of Annan the death-rate for the last month has risen to the high figure of 70 per 1000 per annum. Old persons have died in great numbers.

Workington Infirmary.

The annual report of the Workington Infirmary has been issued, and it shows that ninety-three patients, principally surgical cases and operations, had been treated during the year. The financial position of the infirmary was good, as it closed with a balance in hand of nearly £200. One very satisfactory feature was the workmen's subscriptions, which reached the large sum of over £600.

Health of Ripon.

At a meeting of the Ripon Corporation Sanitary Committee the medical officer of health, Mr. C. Husband, presented his report, which showed that the death-rate for the whole city in 1891 was 20·5 per 1000, and, excluding public institutions, 18·3. Of the total deaths, 16 were of persons not belonging to Ripon, which reduced the death-rate for residents to 17·1. There had been ten deaths from zymotic diseases.

The Malton Medical Officership.

The local papers state that there has been some hitch or mistake in the election of a medical officer for the Malton district, and voluminous correspondence with the Local Government Board has resulted. Some say that a medical officer has been elected, and others say the contrary. It appears that there has been some mistake with the voting cards of the guardians, and probably a new election will take place.

Newcastle-upon-Tyne, Feb. 3rd.

SCOTLAND.

(FROM OUR OWN CORRESPONDENTS.)

The Longmore Hospital for Incurables, Edinburgh.

THE annual meeting of the managers of this institution was held last week, Lord Provost Russell presiding. The report stated that on Dec. 31st, 1890, there were sixty-seven patients in the hospital, and there were admitted during the past year twenty-three, making a total of ninety. Of these, seventeen males and fifteen females died, and four left of their own accord, leaving in the hospital on Dec. 31st last a total of fifty-four. It has been mentioned on several previous occasions that the managers were anxious to increase the accommodation for patients, as they had many more applications for admission than they could provide accommodation for. This report intimates that the necessary building is under course of erection. The old east wing has been pulled down and a new and more suitable wing is being built which will provide accommodation for thirty-four additional patients. Owing to the pulling down of part of the old structure the number of patients had, of course, to be temporarily reduced. When the alterations are completed there will be accommodation for about 100 patients. This will necessarily involve a greater annual outlay, and it is disappointing to note that the public are not subscribing as liberally to the institution as it deserves.

Edinburgh Dental Hospital.

The annual meeting of the directors and contributors to this hospital was held last week, the Lord Provost occupying the chair. From the report it appears that during the year 8617 cases had been treated. The addition of a mechanical department has been of great benefit to the recipients. The report expressed regret that, owing to the proposed extension of the Royal Infirmary, the Dental Hospital would cease to occupy its present premises, which occupied part of the ground included in the proposed extension.

Edinburgh Eye, Ear, and Throat Infirmary.

The institution which bears this name is a dispensary with a few beds attached to it. Its annual meeting was held last week, and from the report it appears that the number of patients in each department has slightly increased, and that the institution continues to do useful work.

The Edinburgh Diseased Meat Case.

The butcher who, as intimated last week, was fined for selling the carcase of a bullock which had died of anthrax has been further fined £20 by the county authorities for not intimating the case to them. This case, and the fact that much meat unfit for food is seized in the city, have caused a small public scare, and people begin to wonder what is safe to eat or to drink.

The Health of Edinburgh.

The mortality last week was 104, and the death-rate 20 per 1000. Diseases of the chest accounted for 50 deaths, and zymotic diseases for 7. The intimations for the week were: Typhoid fever 4, diphtheria 3, scarlatina 18, and measles 50.

General Council of the University of Edinburgh.

A special meeting of this body has been summoned for Friday, chiefly to consider amendments upon some of the later draft ordinances of the Universities Commission.

Feb. 2nd.

IRELAND.

(FROM OUR OWN CORRESPONDENTS.)

Royal College of Surgeons in Ireland: Schools of Surgery.

THE new buildings—anatomical, physiological, and chemical departments—which have been erected at a cost of some £5000, were formally opened on Monday by Mr. H. Gray Croly, president of the College. The dissecting-room is 74 ft. long by 64 ft. wide and 22 ft. high, lighted by a glass roof, and by electric lamps after sunset, while the chemical laboratory is 64 ft. long by 28 ft. wide, above it being the lecture theatre, all being fitted with the electric light. Mr. Croly made some brief remarks on the new buildings, and then said he had one more duty to perform, and that was to confer the honorary public health diploma on one of their most distinguished professors, Sir Charles Cameron, who was known to them not only as one of their professors of chemistry, but also as having been a past president of the College, a diplomate in Public Health, Cambridge University, and was three times re-elected President of the British Public Health Medical Association. Sir C. Cameron, in returning thanks, remarked that it was a source of great satisfaction to him to find that the study of public health was now regarded of so much importance that public medical officers of health were found in all the principal towns in our own countries, as well as all over Europe, and that it was deemed sufficiently worthy to be made the subject of a special diploma, sharing that honour with medicine, surgery, and obstetrics.

National Hospital for Consumption.

A public meeting in support of the proposal to erect a hospital for consumption near Dublin will be held on the 17th inst. at the Royal College of Physicians. Among those who have promised to attend is Her Excellency the Countess of Zetland. The movement has largely engaged

public sympathy, and considerable support may confidently be expected in aid of the necessary funds for erecting and endowing an institution of the kind proposed.

Tercentenary of Trinity College.

The Trinity College Dramatic Committee have selected "The Rivals," by Sheridan, as the play to be performed by the students of the University during the tercentenary celebration.

The Ulster Hospital for Women and Children.

At this hospital the number of cases treated in the wards and the extern departments shows marked progress. A large number of operations were performed, with only three deaths during the year. The building in Fisherwick-place not being satisfactory, the present premises in Mountpottinger were secured. A bazaar is to be held next autumn, the proceeds being for the building fund and ordinary expenses. The hospital is now in every respect fully equipped. A resolution was adopted expressing sympathy with Professor Dill in his illness.

The Samaritan Hospital for Women, Belfast.

During 1890 there were 86 intern and 775 extern patients; in 1891 there were 56 intern and 479 extern patients. By far the greater number of those admitted were surgical cases. During the past few years the training of lady nurses has been undertaken with satisfactory results. There has never been a death from chloroform, although it has, since the foundation of the hospital in 1872, been given in over three thousand cases of operations. There is an increase in the number, and of nearly 50 per cent. in amount, of the public subscriptions for 1891 as compared with 1890, but there has been a decrease of £200 in the receipts from patients, which in previous years was the principal source of income. The late Miss Charters has bequeathed £1000 to the funds.

The Hospital for Sick Children, Belfast.

During the year 1891 there were 347 intern and 7592 extern patients. During the present session forty senior students are attending the clinics at the hospital, which is the largest class held in the institution since its foundation, and this fact indicates the important position which the institution occupies in the Belfast Medical School. The income for the year amounted to £966 4*s.* 9*d.*, and the expenditure to £1010 3*s.*

Belfast Lying-in Hospital.

At the annual meeting, held on Feb. 2nd, I find from the report presented that the number of intern patients (211) has been greater than in any previous year, while 165 were attended at their own homes. The hospital is in good working order. The dispensary, which is open thrice weekly, has been taken advantage of by 1480 women and children. Arrangement has been made for the admission of lady pupils. During the past year ten nurses were trained.

Influenza.

The epidemic of influenza, which for a long time was so prevalent in Belfast, may now be said to have disappeared, there being only a few isolated cases.

The death is reported of John Simpson Jackson, M.B., L.R.C.S.I., surgeon, ss. *Angola*, who was washed overboard in a gale recently. Great sympathy is felt for his father, Sir Robert Jackson, C.B., of Eglinton, Sandimount, near Dublin, a retired Deputy Surgeon-General.

Dr. John Armstrong, Government medical officer, died recently at Dominica, West Indies.

Feb. 3rd.

PARIS.

(FROM OUR OWN CORRESPONDENT.)

KI or NaI? The Prevention of Iodism.

THERE can be no question that the most efficient of all iodine compounds is the potassium salt. Its supremacy in the treatment of tertiary syphilis is undisputed, and in the remedying of the divers symptoms due to arterio-sclerosis no agent gives such satisfactory results. Unfortunately, many patients are intolerant of this drug, and uncomfortable or even grave symptoms of iodism too often render its employment impossible. Nor can it be denied that, with the modern school of practitioners, theoretical considerations, based upon the knowledge gathered in the physiological laboratory that the salts of potassium act as protoplasmic poisons, militate against the administration of a drug which has rendered such good service in the treatment of degenerative processes. One cannot but suspect that such considerations, much less than clinical ones, have induced M. Huchard to prefer, for the last few years, the sodium to the potassium salt. At a meeting of the Société de Thérapeutique held on Jan. 27th, M. Constantin Paul asked M. Huchard if his enthusiasm for the sodium salt had not, as appeared from his recent utterances, somewhat cooled down. M. Paul himself expressed his decided preference for the potassium salt, deeming it to be vastly superior to its sodium congener. The discussion that followed showed that there was a general consensus of opinion as to the inefficacy of sodium iodide in syphilis, and elicited further from M. Huchard the confession that his views were veering round in favour of our old ally the potassium salt. His chief objection to it was its occasional irritating action on the renal filter. The sodium salt was free from this objection, but must be used in much larger doses to produce equivalent results. He believes that in such diseases as angina pectoris and myocarditis, general arterio-sclerosis is present, and consequently renal insufficiency, which the employment of the irritating potassium salt would aggravate. In conformity with the precept formulated originally, I believe, by Sir James Paget, and since endorsed by all English authorities—viz., to prescribe KI associated with some free NH_3,—I have always done so, but without always succeeding in averting iodism. In one syphilitic patient of mine the very first dose of five or ten grains thus prescribed invariably produced coryza, frontal headache, and sometimes a crop of acne. It has, however, never been my lot to witness such a serious form of iodism as œdema of the glottis, although such a *contretemps* has been not unfrequently noted. Quite recently Dr. Kessler of Dorpat recorded such an accident in the person of a woman, into whose vagina he had poured a teaspoonful of a one-third glycerine solution of potassium iodide. It is taught in the Paris school that iodism is more readily induced by small than by large doses. Two German physicians, Drs. Röhmann and Malachowski of Breslau, have been lately experimenting with bicarbonate of sodium as an antidote for iodism, believing that the ingestion of this salt, by rendering the blood alkaline, prevents the decomposition of potassium iodide and the consequent liberation of iodine in the free state. Two years' experience has convinced them that in bicarbonate of sodium, given synchronously, in two daily doses of forty or fifty grains, with potassium iodide, an agent has been discovered capable of counteracting, or even altogether preventing, the development of toxic symptoms.

Then and Now.

Professor Charcot is probably the most renowned teacher of which this Faculty can at present boast, hardly a foreigner visiting the Paris hospitals failing to make the classical pilgrimage to the Salpêtrière, where the learned and popular neurologist exercises sway. It may consequently interest the medical world to learn that at least one of M. Charcot's (probable) ancestors was an adept in the practice of *suggestion*, only the subjects whom he influenced were not hysterical girls, but—wild cats! The *modus operandi* also differed considerably, as will be perceived, from that now in vogue in the wards of the Salpêtrière. The following passage, which is extracted from Boguet's work entitled "Discours des Sorciers," third edition, Lyon, 1610, I transcribe without modernising the racy old French in which it was written. The *Progrès Médical* states that M. Charcot has still some relatives living in the same Gex district (now included in the Department of the Ain) mentioned in the extract: "Le semblable advint environ quarante ans lorsque les Bernois tenoient le Bailliage de Gex, en la personne d'un Charcot, homme de la mesme Terre et qui estoit de la religion prétendue réformée; celuy-cy fut assailly de nuict au bois de Rats, par une multitude de chats, à l'encontre desquels il se mit en défense, se servant d'une espée qu'il portoit, mais cõme il recogneut que son espée ne luy profitoit en rien, il fit le signe de la Croix, et lors tous les chats disparurẽt. Le Bailly nommé Augustin de Lutherno Bernois, ayant esté adverty du faict, mande Charcot qui luy confirma la chose en la sorte qu'elle a esté rapportée, et lors le Bailly luy dit, que s'il recognoiszoit que le signe de la Croix luy

fut profitable, il s'en deust tousiours aider à l'advenir. Je tiens l'histoire du sieur de Pougny, Gentilhomme de la terre de Gex et personnage d'honneur."

Insanity in Paris.

From a report just issued by Dr. Paul Garnier, physician to the special infirmary attached to the Préfecture de Police, it appears that insanity has increased in notable proportions (30 per cent.) in this city during the period included between 1872 and 1888. In the former year there were, in fact, registered at the Prefecture 3080 cases, as against 4449 in 1888, the grand total for that period of sixteen years being 62,572, including 34,882 males and 27,770 females.

Street Demonstrations by Medical Students.

Great dissatisfaction has been aroused in student circles by a recent announcement, to the effect that, in order to reconcile the terms of medical studies with those of the new military law, the limit of age at which the post of interne or house surgeon or physician can be competed for would henceforth be fixed at twenty-five. Numerous petitions have already been addressed to the authorities, with a view of having the obnoxious regulation amended. Feeling runs high on the subject. On Wednesday, the 27th ult., several hundred medical students repaired in groups to the headquarters of the Assistance Publique in the Avenue Victoria, and noisily protested against the measure. Dr. Peyron, the director, succeeded in calming the tumult by assuring his young friends that the matter was to be reconsidered, and that, in arriving at a final decision, their true interests would be kept in mind. Both the *Progrès Médical* and the *Bulletin Médical* appeal to the body of students to maintain a dignified and calm attitude, and to refrain from compromising the success of their agitation by holding disorderly street demonstrations.

Paris, Feb. 3rd.

BERLIN.

(FROM OUR OWN CORRESPONDENT.)

Street Hygiene.

AT a recent meeting of the German Public Health Society Dr. Theodor Weyl spoke on the street hygiene of Paris and London, and recommended the adoption in Berlin of many of the arrangements in vogue at those places. The gist of his remarks was as follows: Wooden pavement has been in use in London and Paris for many years past, and has proved a great success, even in the most frequented streets. The fact that it has been less successful in Berlin may be due to faults of construction and treatment. In Paris and London there are no rails in streets paved with wood. The pavement is copiously watered. Drains and pipes are not laid under it, but under the side walks. The main thing, however, is good construction. In London and Paris sweeping is always preceded by watering, which is not the case here, to the serious detriment of the public health. The public closets in Paris are not worthy of imitation, because hygienic considerations are to a large extent subordinated to advertising purposes, but those of London are exemplary. The depositing of rubbish within or even in the immediate vicinity of cities is altogether to be condemned. The removal of snow costs Berlin about £19,000 a year, because it is not thrown into the river or sewers as in London and Paris, but carted out of the city. In conclusion, Dr. Weyl warmly recommended the London plan of regulating traffic by placing the lamp-posts in the middle of the street.

Dangerous Stoves.

The President of Police in Berlin has repeatedly warned the public against the use of certain forms of stoves. The President states that one case of poisoning by carbonic oxide occurred in Berlin and two in Wiesbaden in the winter of 1887-88, owing to the use of such stoves. It has been proved by experiments in the Hygienic Institute here that such stoves are dangerous.

Influenza.

The number of deaths in Berlin from influenza from the beginning of the present epidemic till the 16th ult. was 492. Of the fifteen normal schools of the kingdom of Saxony, twelve are closed, owing to the epidemic.

Statistics.

The number of marriages in Berlin in the week which ended on the 16th ult. was 157. The number of children born alive was 974, of whom 104 were illegitimate; 24 were born dead, of whom 5 were illegitimate. The number of deaths reported was 680—1 from typhus fever, 1 from quinsy, 3 from roseola, 3 from syphilis, 7 from whooping-cough, 7 from gastro-intestinal catarrh, 9 from measles, 11 from scarlet fever, 14 from diarrhœa, 14 from diarrhœa with vomiting, 18 from cerebral apoplexy, 21 from diphtheria, 28 from senile decrepitude, 32 from influenza, 63 from pneumonia, and 100 from phthisis. Seven persons died violent deaths, 3 of whom were hanged, 3 shot, and 1 driven over. Six of these deaths were suicides. The death-rates of the chief German cities were as follows: Krefeld, 9·9; Düsseldorf, 16·5; Stuttgart, 16·9; Strasburg, 17·2; Frankfort, 18·5; Leipsic, 18·7; Elberfeld, 19·8; Hanover, 20·7; Bremen, 21·1; Barmen, 21·2; Stettin, 21·4; Dantzic, 21·7; Berlin, 21·8; Breslau, 25·4; Dresden, 25·6; Königsberg, 25·8; Aix-la-Chapelle, 26·5; Nuremberg, 26·5; Hamburg, 26·6; Altona, 27·6; Magdeburg, 28·7; Munich, 30·4; Cologne, 31·7; Chemnitz, 33·8.

Berlin, Feb. 2nd.

Obituary.

ALFRED CARPENTER, M.D.LOND., M.R.C.P.LOND., J.P., &C.

FOR the last forty years the name of Dr. Carpenter has been at once familiar to and respected by all who have been interested in the progress of sanitary matters during the past half-century. Himself the son of a medical man, his general and medical education received marked attention, and his career as a student of St. Thomas's Hospital, when it was in less pretentious quarters than at present, is one which will compare with the most outstanding in the profession. He took several qualifications, ultimately becoming M.D. of London. His work was one of reform, and extended into many fields of labour. Early closing, sanitary progress, public baths, establishment of sewage farms, house drainage, and adulteration of food were subjects on which he spoke and wrote with unfaltering voice and unflinching pen. Every movement for the advancement of science and literature found in him a warm supporter. His writings embrace almost every sphere of sanitary work. He was a member of the Health Committee of the Social Science Association for many years, and its transactions testify to the work he performed. As a member of the Sanitary Institute he materially assisted the end in view. The motive power of his action was the belief so frequently expressed that the establishment of healthy homes for working people was the only true solution of the main problem in sanitary science. "You put the poor creatures in such conditions that their health has been failing for months, and when they die you blame the drainage." Dr. Carpenter would have heartily endorsed every syllable of this truth. His Glasgow paper, read in St. Andrew's Hall, entitled "Public Health: a Working Man's Question," was founded upon that text. It would have been marvellous beyond question if the ideas of a man possessed of his qualities of origination had not clashed frequently and rudely with certain interests. He did not escape calumny. No man of action ever does. So great was the friction engendered, on the only occasion on which he sought political honours, that he was set upon and roughly handled, and "eventually ducked in a pond." He suffered for his principles in good company. The roll of such is not too long, but every name on it is stereotyped for ever, for good, and posterity will read and think, and the verdict will be different. He was a magistrate for Croydon. In that capacity he betrayed a remarkable belief in the ancient theory of "sparing the rod and hating the juvenile offender." His invariable remedy for this class of delinquent was "a sound whipping." Had he survived he would have been elected to the post of chief magistrate. Years ago this honour was offered to him, but his many other public duties prevented his acceptance of the post. He was a vice-president of the British Medical Association, having been president of its council from 1879-81.

Medical News.

UNIVERSITY OF CAMBRIDGE.—At a congregation held on Jan. 28th the degrees of B M. and B S. were conferred on the following:—

George Tolcher Eccles, Downing.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.—The following gentlemen, having conformed to the by-laws and regulations and passed the required examinations, were at a meeting of the College on Jan. 28th admitted Licentiates:—

Adams, Alfred, St. Barthol.
Adams, E. Weaver, King's Coll.
Adams, W. Francis, King's Coll.
*Archer, Stafford L., St. Barthol.
Armstead, Hugh W., St. Barthol.
Atlee, John, St. Barthol.
Barker, Chesman, St. Barthol. & Sheffield.
Bell, Jas. Adamson, King's Coll.
Biddle, Henry George, Guy's.
Billson, Charles, St. Thomas's.
Bishop, George T., Charing-cross.
Blackwell, A. S., St. Barthol.
Bolus, Harry Boulcott, Guy's.
Braithwaite, Charles B., Guy's.
Browne, John James, Guy's.
Brownlow, Harry L., St. Barthol.
Burden, Henry, St. Thomas's.
Cooke, William H., St. George's.
Cooper, Arthur T., Univ. Coll.
Day, Joseph H., Charing-cross.
*Dolamore, W. Henry, St Mary's.
Dorman, M. R. P., St. Thomas's.
Drake, W. Elliot, St. Thomas's.
*Eccles, R. Burton, St. Thomas's.
Ellis, Fred, London.
English, Thos. Harks, London.
Evans, John, Liverpool.
Everett, Ernest W., St. Barthol.
Fearnley, Jonathan, Leeds.
Fennings, Arthur Allen, St. Mary's & Durham.
Finley, Harry, Univ. Coll.
*Fraser, Reginald Conrad. Guy's.
Freeland, Douglas L., Middlesex.
Glover, Lewis G., St. Barthol.
Graham, Charles H., St. Barthol.
Green, Joseph, Manchester.
*Greenalgh, Arthur, Manchester.
Griffiths, G. Batho, St. Barthol.
Haslam, William Arthur, Guy's.
Haydon, Arthur Geo., St. Barthol.
Hayes, William A., Univ. Coll.
Higgs, Walter Alpheus, Guy's.
Hignett, Lionel W., Edinburgh.
Hopkin, Richard. London.
Hutton, James William, Leeds.
Iliewicz, Edmund M., St. Mary's.
Jerome, George P., Birmingham.
Jones L. Gwynn D., Manchester.
Jones, Wm. Black, St. Barthol.
Kendall, Herbert W., Middlesex.
Kitching, Charles A., London.
Lacey, Allan Ramsey, Guy's.
Lee, Sidney Herbert, Middlesex.
*Leicester, Thomas, St. Thomas's.
Lemarchand, A. W., St. Barthol.
Lewarne, Frank, St. Barthol.
Lewis, Herbert W., Westminster.
Lister, Septimus R., St. Barthol.
Lloyd, Fredk. Geo., St. Barthol.
Lord, Percy, Guy's.
Lumley, Fredk. Davidson, Guy's.
Lunn, Cyril R., Birmingham.
*McAnally, Arch. A., King's Coll.
McKinnon, Arch. A., King's Coll.
McMichael, A. W., Birmingham.
Marin, F. Baptiste, Westminster.
*Martland, Thomas, Manchester.
Mathews, Wm. Robert, London.
Miller, John, St. Barthol.
Minshall, Arthur G., Univ. Coll.
Morgan, Harry de R., St. George's.
Morrison, James, St. Barthol.
*Nash, Charles, King's Coll.
Newby, Gervase E., Univ. Coll.
Nicholls, Sydney R., London.
Norman, George, Westminster.
Norris, Arthur Ernest, Guy's.
Nuttall, Walter W., St. Barthol.
Passmore, J. E. Sanders, London.
Pauling, W. T., St. Thomas's.
Phillips, Percy C., St. Thomas's.
Pickford, James S., Manchester.
Pitt, Tom, Bristol.
Porter, Frank C., Charing-cross.
Powrie, Percy C., Univ. Coll.
Prall, Cedric B., St. Thomas's.
*Prosser-Evans, J., Univ. Coll.
Prynne, Harold V., Middlesex.
Ralph, C. H. Danson, Guy's.
Ramsay, George, King's Coll.
*Richardson, W. J., King's Coll.
Roth, Walter E., St. Thomas's.
Rowell, John George, Leeds.
Rutter, F. Burchett, London.
Sargent, Hugh Cann, London.
Senior, Harold D., Charing-cross.
Star, P. Hohling Mills, Bristol.
Steegmann, E. John, St. Mary's.
Thomas, Henry, St. Barthol.
Thomas, William, London.
Thorne, Bertholi Bezly Thorne, St Barthol.
Turner, Joseph G., St. Thomas's.
Turner, Olivier Polhill, Univ. Coll.
Visick, C. H. Clarence, Univ. Coll.
Volsin, E. O. Bishop, Univ. Coll.
Wallace, F. Gore, St. Thomas's.
Warner, Thomas, King's Coll.
Waters, H. Geo., St. Thomas's.
Watkins, D. J. G., St. Barthol.
Weichert, Charles J., Univ. Coll.
Whiteford, Chas. H., St. Barthol.
Whitehead, A. Longley, Leeds.
Wiglesworth, T. Ridler, Bristol.
Wild, Henry Sydney, St. George's.
Wilkinson, Harry Bacon, Guy's.
Williamson, J. H., Manchester.
Wood, Cyril Geo. Russ, Bristol.
Worthington, Harry E., Guy's.
Wrench, Edward Branson, Cambridge & St. Thomas's.
Wylie, J. T. Roy, St. George's.

* Candidates who have not presented themselves under the Regulations of the Examining Board.

ROYAL COLLEGES OF PHYSICIANS AND SURGEONS IN IRELAND: CONJOINT SCHEME.—The following candidates have passed the Final Examination:—

E. H. Beaman, H. Bouchier-Hayes T. F. Dillon, J. J. M. Dowzer, J. H. Elmes, M. Ferguson, F. W. Foott, E. F. Frazer, W. C. Hamilton, M. Keay, H. B. Ludlow, E. W. Lynch, J. M. Mangan, R. Moynahan, A. W. Power, G. H. Russell, I. G. Warren, R. J. White, G. T. Whyte, D. E. Williams.

The following have passed in the subjects indicated:—

Medicine.—M. J. Chevers, D. H. Foley, P. J. Garland, F. A. Madden, A. R. Moore, W. W. Scarlett, S. W. Wilson, Jane Wynne.

Surgery.—H. W. Cave, M. J. Chevers, C. E. Cowen, D. H. Foley, P. J. Garland, F. J. Greeves, A. R. Moore, W. W. Scarlett, Temple Smyth, Frederick O. Stoker.

Midwifery.—I. Crumley, F. I. Flood, F. J. Greeves.

BRITISH MEDICAL SERVICE.—The following is the list of Surgeons on probation of the Medical Staff of the British Army who were successful at both the recent London and Netley examinations. The prizes are awarded for marks gained in the special subjects taught at the Army Medical School. The final positions of these gentlemen are determined by the marks gained in London added to those gained at Netley, and the combined numbers are accordingly shown in the list which follows:—

	Combined Marks.		Combined Marks.
*Pilcher, E. M. ..	6994	Mitchell, L. A. ..	4549
Johnson, H. P. ..	5421	Fleming, C. C. ..	4533
Beyts, W. G. ..	5219	Hennessy, J. ..	4516
Stalkartt, H. A. ..	4883	Martin, C. B. ..	4501
Dunn, H. N. ..	4432	Buchanan, G. J. ..	4395
Withers, S. H. ..	4794	Lawson, C. B. ..	4366
Morphew, E. M. ..	4744	Hughes, G. E. ..	4344
Anderson, E. C. ..	4648	Kelly, J. F. M. ..	4337
Tyacke, N. ..	4619	Crawford, G. S. ..	4286
Holt, R. H. E. G. ..	4562	Alexander, J. D. ..	4200

* Gained the Montefiore second prize.

INDIAN MEDICAL SERVICE.—The following Surgeons on probation were successful at both the recent London and Netley examinations:—

	Combined Marks.		Combined Marks.
Seton, B. G. ..	6079	Mitter, R. K. ..	5589
*Sprague, W. C. ..	6044	Armstrong, W. E. A. ..	5507
†Elliot, R. H. ..	6027	Yeates, R. A. ..	5456

* Gained the Martin Memorial Gold Medal with the De Chaumont prize in Hygiene, the prize in Pathology presented by the Director-General of the Army Medical Department, Sir William Mackinnon, K.C.B., and the Herbert prize of £20.

† Gained the Montefiore Medal and prize of 20 guineas, and the prize in Clinical Medicine presented by Surgeon-General W. C. Maclean, C.B.

CREMATION.—In view of the increase in the practice of cremation, the directors of the General Cemetery Company have decided to build within the monumental chambers at Kensal-green a columbarium or receptacle for cinerary urns.

THE GERMAN HOSPITAL, DALSTON.—The annual report just circulated shows that the number of in-patients admitted during the past year was 1536, of which 303 were cases of accident. In the same period, 364 patients were received into the convalescent home. The total number of out-patients treated at the hospital, and the Eastern and Western Dispensaries, was 24,757. The financial statement shows a balance of £278 for the general fund. Another ward for women was much needed.

PROPOSED NEW COUNTY ASYLUM FOR LANCASHIRE. At the meeting of the Lancashire Asylums Board at Preston on the 28th ult. it was reported that the present asylums were crowded, and that the normal increase of lunatics in Lancashire was 200 per annum. It was resolved to recommend to the County Council the erection of an institution for the reception of harmless incurable lunatics and imbeciles combined, with a school for juvenile imbeciles under separate superintendence and on the same estate.

MANCHESTER MEDICO-ETHICAL ASSOCIATION.—The following gentlemen have been elected by the Committee for election as office-bearers and committee for the year 1892 President: Dr. Henry Ashby. Vice-Presidents: Drs. Alfred Gudson, Simeon Holgate Owen, William Japp Sinclair, and Mr. John Broadbent. Treasurer: Dr. Lloyd Roberts. Secretaries: Dr. Frederick H. Collins, and Mr. John Ferguson. Committee: Drs. Hugh Walter Boddy, Henry A. G. Brooke, Thomas Harris, James Holmes, John Fisher Le Page, William Milligan, Seigmund Moritz, Robert A. Murray, and Charles Gordon Lennox Skinner; Messrs. Joseph Foster, Herbert Lund, and John Antoine Palanque.

IPSWICH BOARD OF GUARDIANS.—At the meeting of the board at the Town Hall on the 29th ult. the following report of the Out-Relief Committee was presented, and ultimately adopted:—"Your committee, having fully considered the question of medical relief, recommend:—1. That there should be one medical officer instead of three. 2. That Mr. Edwards should be paid a retiring pension of £60 a year. 3. That Mr. Adams should be paid a similar pension of £50. 4. That the medical officer should attend at the out-relief station every morning at 10, for the purpose of seeing patients. 5. That the medical officer should employ a deputy, equally qualified with himself. 6. That the deputy be allowed to see chronic cases, and otherwise assist the medical officer in the discharge of his duties. 7. That the guardians should contract with a druggist for the supply of all drugs, at their expense. 8. That the druggist supplying the drugs should send a dispenser to attend at the out-relief office morning and evening to make up the medical officer's prescriptions. 9 That the medical officer should be paid £280 a year, rising £10 a year to £320."

SIR P. DUN'S HOSPITAL, DUBLIN.—This institution has received, in response to the special appeal for funds, a cheque for £200 from Lord Iveagh, and £100 each from Sir E. Hudson Kinahan, Bart., and Mr. John Jameson.

FOLKESTONE.—Dr. Ross, of Christ Church-road, Folkestone, has been unanimously chosen a member of the Library and Museum Committee, in the place of Mr. Saunderson, deceased.

HERTFORD GENERAL HOSPITAL.—The annual report for the year 1891 shows an increase in the number of both in- and out-patients. There was a decrease in the year's receipts (chiefly arising from the falling off of donations and legacies) amounting to £387 3*s.* 9*d.*

WELLINGTON COLLEGE.—A special meeting of the governors of Wellington College was held yesterday, at the Fine Arts Commission Room, Palace of Westminster. The governors present were—Colonel Talbot (vice-president), his Royal Highness the Duke of Connaught, his Royal Highness Prince Christian, the Duke of Wellington, the Bishop of Rochester, Sir George Russell, Sir Lintorn Simmons, Sir Dighton Probyn, Sir George Harman, Mr. Walter, and Mr. J. F. Chance (Secretary).

THE PREVENTION OF CRUELTY TO CHILDREN.—During the quarter ended Dec. 31st, 1891, the National Society for the Prevention of Cruelty to Children investigated 1974 complaints of cruelty, affecting the welfare of 4662 children. In 1168 cases warnings were given to the offenders; in 280 cases the offences were of so gross a nature as to necessitate prosecution (convicted 265, discharged 15); and the rest were otherwise dealt with. Fifty-four years of imprisonment and £51 in fines were inflicted.

DEVON AND EXETER MEDICO-CHIRURGICAL SOCIETY. The following gentlemen have been elected office-bearers for 1892:—President: John Woodman, M.D., F.R.C.S. Vice-President: James Somer, M.R.C.S. Treasurer: J. D. Harris, M.R.C.S. Council: E. J. Domville, M.R.C.S., J. Mortimer, M.B., C. E. Bell, M.R.C.S., C. H. Wade, M.A., M.R.C.S., W. Langran, L.R.C.P.E., and A. Curtis, L.R.C.P.L. Auditors: A. C. Roper, F.R.C.S.E., and J. M. Ackland, M.R.C.S. Secretary: A. G. Blomfield, M.D.

TORBAY HOSPITAL AND DISPENSARY.—This charity maintains its utility, and continues to extend its benevolent work. The cash account again shows a deficiency, and the board had resolved to apply to current expenses the amounts in hand received for life governorships to reduce the overdraft. The executors of the late Miss Lavinia Warrington have offered to bestow £7000 for the purpose of improving and enlarging the hospital, which the governors have long contemplated. This generous offer has been accepted. A ward will be named after the donor.

FOOTBALL CASUALTIES.—On the 26th ult. a young man sustained a fracture of the leg while playing in a match between the Cardiff Police and Corporation Officials. He was taken to the infirmary and detained.—On Saturday, in a match between Heywood and Heywood Central Clubs, a player was kicked on the left knee, and on medical assistance being obtained it was found he had sustained a serious fracture of the "knee-cap."—On the same day, while playing for the Dunfermline Athletic Club against the Lochgelly United, in a match at Dunfermline, a young man had one of his legs fractured; and during a match between the Birmingham Wycliffe and the Lichfield Leomansley Clubs a scrimmage occurred, and the Wycliffe captain sustained a fracture of his leg above the ankle.

VOLUNTEER MEDICAL ASSOCIATION.—The usual quarterly meeting of the council was held at 101, Great Russell-street, on Wednesday, Jan. 27th. A resolution was passed expressing respectful sympathy and condolence with the president, Field Marshal H.R.H. the Prince of Wales on the melancholy event of the death of H.R.H. the Duke of Clarence and Avondale. The draft of the annual report for 1891 was read and approved, and it was ordered to be printed and circulated. The report of a committee lately appointed to revise the regulations for the Ambulance Challenge Shield was received, and the regulations for the competition as amended by the committee were adopted. Entries for the challenge shield must be sent to the hon. secretary before April 30th. The next meeting of council will be held on April 27th.

OVERLOADING STEAMSHIPS. — The stipendiary magistrate at Cardiff last week inflicted the maximum fine of £100 each in three cases of overloading steamships at Port Said, Gibraltar, and at Bilbao. In giving his judgment he stated that the jeopardy and loss of human lives directly and clearly attributable to overloading had officially been brought to his notice.

WINDSOR AND ETON ROYAL DISPENSARY AND INFIRMARY.—During the year 1891, 291 patients had been admitted into the institution, the largest record for some years, and 4257 out-patients were attended at the dispensary, or treated at their own homes. The income had fallen off considerably during the year; but, taking into consideration the great amount of sickness and distress which had been prevalent, the balance-sheet was a favourable one.

BRISTOL ROYAL INFIRMARY.—At a special meeting of the governors, held on the 26th ult., to consider a proposed alteration in the rules in reference to the mode of election to vacancies on the honorary medical and surgical staff, it was unanimously resolved that: "Every vacancy in the honorary medical and surgical staff shall be filled up by a committee of election, consisting of president, vice-presidents, and consulting physicians and surgeons, including the obstetric physician and ophthalmic surgeon, and members of the committee of management, together with twenty-one governors, to be appointed only at the general board to be held in March in each year. Whenever a vacancy may occur in the office of physician, surgeon, obstetric physician, ophthalmic surgeon, dental surgeon, assistant physician, or assistant surgeon, the committee of management shall, upon announcement of the vacancy, summon a meeting of the committee of election to fill the same, on a day to be notified on the summons, and proceed to the election accordingly." It was stated that this alteration would reduce the expense to the candidates, and abolish the necessity of canvassing.

METROPOLITAN ASYLUMS BOARD.

Return of Patients remaining in the several Fever Hospitals of the Board at Midnight on February 2nd, 1892.

Hospital.	Beds occupied.						Total accommodation.
	Scarlet fever.	Diphtheria.	Typhus fever.	Enteric fever.	Other diseases.	Total.	
Eastern Hospital	186	52	..	35	1	274	442
North-Western Hospital	245	36	..	12	..	273	411
Western ,,	105	22	..	13	4	144	234
South-Western ,,	197*	43	..	19	2	261	350
South-Eastern ,,	196	15	1	61	4	276	424
Northern ,,	365	20	..	13	..	398	480
Totals	1273	188	1	153	11	1626	2331

* Infant and mother.

SMALL-POX.—*Atlas* hospital ship, 6.

Appointments.

Successful applicants for Vacancies, Secretaries of Public Institutions, and others possessing information suitable for this column, are invited to forward it to THE LANCET *Office, directed to the Sub-Editor, not later than 9 o'clock on the Thursday morning of each week for publication in the next number.*

BOWER, ERNEST DYKES, M.R.C.S., L.S.A., has been appointed Surgeon to the General Infirmary, Gloucester, and the Gloucestershire Eye Institution, vice A. M. Sydney-Turner, resigned.

BULL, W. C., M.B. Camb., F.R.C.S., has been appointed Aural Surgeon to the St. George's Hospital, London.

BURKITT, J. C. S., M.D., M.Ch., D.P.H., R.C.S. Irel. has been reapointed Medical Officer of Health for the Whitwick Urban District.

CLARK, W. W., M.D. Edin., M.R.C.S., has been reappointed Medical Officer for Wellingborough.

COLE, ARTHUR, L.R.C.P., L.R.C.S. Irel., has been appointed Medical Officer at Ayr, Queensland.

DIMMOCK, A. F., M.D. Durh., M.R.C.S., has been reappointed Medical Officer of the Harrogate Cottage Hospital.

DONALDSON, GEORGE, A.B., M.B., B.Ch., B.A.O. Dub., has been appointed Medical Officer to the Castle Shane Dispensary District Monagan Union, vice Robert Donaldson, resigned.

GIVEN, J. C. M., L.S.A., has been appointed Assistant Medical Officer of the Derby Borough Asylum.

GOUGH, J. HARLEY, L.R.C.P. Lond., M.R.C.S., has been appointed Honorary Surgeon to the Tavistock Cottage Hospital.

GRIFFITH, JAS. DE B., M.B., M.Ch. Dub., has been appointed a Medical Officer for the Sunbury Lunatic Asylum, Victoria, Australia.

HEARD, ROBERT LYNN, M.B., B.Ch. R.U.I., has been appointed Medical Officer to the Monkstown Parochial Benefit Society.

HILL, T. EUSTACE, M.B., C.M. Edin., B.Sc., has been reappointed Medical Officer of Health for South Shields.

HUME, G. H., F.R.C.S. Edin., has been appointed Consulting Surgeon to the Children's Hospital, Newcastle-on-Tyne.

HUNTER, W. L., M.D., B.Ch., D.P.H. Eng., has been appointed Medical Officer of Health to the Pudsey Local Board.

JONES, GEO. F., M.R.C.S., has been appointed Medical Officer of Health for Southend.

KENNEDY, F. W. M.D., B.Ch., B.A.O.Dub., has been appointed House Surgeon to the Sir Patrick Dun's Hospital, Dublin.

LOVERIDGE, A. W., M.R.C.S., has been appointed Honorary Surgeon to the Newport (Mon.) Infirmary.

MACAULAY, THOS., M.R.C.S., L.M., has been reappointed Medical Officer of Health for the Market Harborough Rural District.

MUIR, JAMES M. M., M.B., M.Ch. Glasg., has been appointed a Public Vaccinator at Woodend, Victoria, Australia.

NORRIS, L. FREDK., M.B., C.M. Glasg., has been appointed Junior House Surgeon to the Borough Hospital, Birkenhead.

OZANNE, F. N., L.R.C.P. Lond., M.R.C.S., has been reappointed Medical Officer of the Harrogate Cottage Hospital.

PAGE, FREDERICK, M.D., has been appointed Consulting Surgeon to the Children's Hospital, Newcastle-on-Tyne.

RIDDELL, JOHN S., M.B., C.M. Aberd., has been appointed Medical Officer to the Holborn Lodge of Oddfellows (Caledonian Order).

ROBERTS, N. E., M.B., C.M. Edin., has been appointed Visiting Physician to the Grafton-street and Parkhill Hospitals, Liverpool.

ROBERTS, C. GORDON, M.A., M.B., B.C. (Cantab.), has been appointed Medical Officer of Health to the Town of Halstead, Essex, and Medical Officer to the Second Division, and Public Vaccinator to the First and Second Divisions of the First District, Halstead Union.

SHARMAN, ERIC H., M.R.C.S., L.R.C.P., has been appointed House Surgeon to the Hospital for Sick Children, Great Ormond-street, W.C.

SPENCER, W., L.R.C.P., L.R.C.S. Edin., has been reappointed Medical Officer of Health for the Borough of East Retford.

STEELE, H. O., M.R.C.S., has been reappointed Medical Officer of Health for Gomersal.

SULLIVAN, EDWD. F., M.D., M.Ch., L.M. R.C.P. Irel., has been appointed Health Officer for the North Yarrawonga Shire, Victoria, Australia.

TAYLOR-GENGE, T., L.D.S., has been appointed Dental Surgeon to the Bristol General Hospital, vice T. Cooke Parson, M.R.C.S., L.D.S., deceased.

WILLIAMS, NEVILLE, M.B. (Cantab), M.R.C.S., has been reappointed Medical Officer of the Harrogate Cottage Hospital.

Vacancies.

For further information regarding each vacancy reference should be made to the advertisement.

CAPE COPPER COMPANY.—Assistant Surgeon for Cape Colony. (Apply, by letter only, to the Secretary, No. 9, Queen-street-place, London, E.C.)

CITY OF LONDON HOSPITAL FOR DISEASES OF THE CHEST, Victoria Park, E.—Assistant Physician. (Apply to the Secretary. Office, 24, Finsbury-circus, E.C.)

DENTAL HOSPITAL OF LONDON, Leicester-square.—Two Assistant Dental Surgeons.

DISTRICT INFIRMARY, Ashton-under-Lyne.—Junior House Surgeon and Dispenser. Salary £50 per annum, with board and lodging.

EAST LONDON HOSPITAL FOR CHILDREN, Shadwell, E.—Resident Medical Officer for two years. Salary £30 per annum, with board, lodging, and washing.

EAST LONDON HOSPITAL FOR CHILDREN, Shadwell, E. — House Physician. Board and lodging provided.

GENERAL HOSPITAL, Birmingham.—House Governor. Salary £300 per annum, with board and apartments.

HOSPITAL FOR WOMEN, Soho-square, London.—House Physician for six months. Salary £30 for that period.

HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST, Brompton.—Assistant Physician.

KENT COUNTY LUNATIC ASYLUM, Chartham, near Canterbury.—Medical Superintendent. Salary £600 per annum, with unfurnished house, gas, washing for himself and family, and produce of garden.

LONDON LOCK HOSPITAL AND ASYLUM, Harrow-road, W., and 91, Dean-street, Soho, W.—Surgeon to in-patients and out-patients at 91, Dean-street, Soho, W., for two years.

LONDON COUNTY ASYLUM, Cane-hill, Coulsdon, Surrey.—Fourth Assistant Medical Officer. Salary £150 per annum, rising by £5 to £160, with board, lodging, and washing.

LONDON HOSPITAL, Whitechapel, E.—Assistant Surgeon.

METROPOLITAN HOSPITAL, Kingsland-road, N.E.—Surgeon.

MR. E. J. HARWOOD, 18, Ely-place, Holborn, E.C.—Medical Officer.

NORFOLK COUNTY ASYLUM, Thorpe, Norwich.—Senior Assistant Medical Officer for five years. Salary £160 per annum, with board, lodging, and washing.

PARISH OF LOCK GOILHEAD AND KILMORICK, N.B.—Medical Officer. Salary £70 per annum.

QUEEN'S HOSPITAL, Birmingham.—Casualty Surgeon. Annual honorarium £50.

ROYAL HOSPITAL FOR CHILDREN AND WOMEN, Waterloo-bridge-road, S.E.—Resident Medical Officer. Salary £70 per annum, with board and apartments.

SOUTH SHIELDS UNION.—Medical Officer for the Union Workhouse. The salary, which will include remuneration for all operations and accouchements, will be at the rate of £250 per annum, together with a fee of 1s. 6d. for each child vaccinated in the Workhouse.—(Apply to the Clerk to the Guardians, Union Offices, South Shields.)

ST. THOMAS'S HOSPITAL MEDICAL SCHOOL, Albert Embankment, S.E.—The Chair of Chemistry.

UNIVERSITY OF GLASGOW.—Three Assistant Examiners. The annual fee to each Examiner is £30, and the term of office in each case is four years from April 1st next.

Births, Marriages, and Deaths.

BIRTHS.

SILCOCK.—On Feb. 1st, at 52, Harley-street, W., the wife of Arthur Quarry Silcock, M.D., B.S. (Lond.), F.R.C.S. Eng., of a son.

HANLY.—On Jan. 29th, at Ormskirk, the wife of Dr. J. J. Hanly, M.A., of a son.

FAWSSETT.—On Jan. 31st, at Lewes, Sussex, the wife of Frank Fawssett, M.B., B.S. Lond., of a daughter.

INKSTER.—On Jan. 24th, at Broomhill Lodge, Sheffield, the wife of S. Macaulay Inkster, M.D., of a daughter.

MANLEY.—On Jan. 24th, at New-street, West Bromwich, the wife of Dr. Herbert Manley, of a son.

COLLIER.—On Jan. 29th, at St. Mary's Entry, Oxford, the wife of Wm. Collier, M.D., of a son.

JAMES.—On Jan. 19th, at Cazenove-road, Stamford-hill, N., the wife of C. A. James, L.R.C.P., M.R.C.S., D.P.H. Eng., of a son.

HAKE.—On Jan. 30th, at Inverness-terrace, Fulham, S.W., the wife of Dr. H. Wilson Hake, of a son.

OPENSHAW.—On Jan. 29th, at Wimpole-street, Cavendish-square, W., the wife of T. Horrocks Openshaw, M.S., F.R.C.S. Eng., of a son.

SMELT.—On Feb. 1st, at The Villa, Newent, Glos., the wife of Frank Hayes Smelt, Surgeon, of a son.

MURDOCH.—On Feb. 2nd, at Morningside-road, Edinburgh, the wife of T. M. Burn Murdoch, M.B., of a son.

MARRIAGES.

ROUTH—WATSON.—On Jan. 28th, at Rosehall U. P. Church, Edinburgh, by the Rev. Lewis Davidson, Mayfield Free Church, Randolph Henry Felix Routh, M.R.C.S., L.R.C.P., of Bridgewater, Somerset, youngest son of C. H. F. Routh, M.D., of Montagu-square, London, to Jean Gladstone, eldest daughter of Walter Watson, M.D., of Edinburgh, late of Midcalder.

CONWAY—FORSYTH.—On Jan. 27th, at the Parish Church, Sale, Basil Wiseman Conway, M.R.C.S., L.R.C.P., of Longsight, Manchester, eldest surviving son of the late Edwin Conway, of Stalybridge, to Jane, only daughter of the late Henry Arthur Forsyth, of Charlton Drive, Sale, Cheshire.

EADES—SAVAGE.—On Jan. 27th, at St. Anne's Church, Wandsworth, S. O. Eades, L.R.C.P., L.R.C.S. Edin., of Ipswich, to Teresa Julia Mary Savage, of Struan, Wandsworth-common, S.W.

RICHARDSON—LEVEAUX.—On Jan. 28th, at Hornsey Church, Alfred Ernest Richardson, M.D., M.R.C.S., of Tamworth, to Kate Josephine, eldest daughter of the late Mr. E. H. Leveaux, the Grange, Brookgreen, W.

DEATHS.

ADAMS.—On Jan. 31st, at Tower Lodge, Regent's-park-road, Wiliam Adams, F.R.C.S., J.P., aged 65.

BUTLER.—On Jan. 21st, at Cosham, Hants, suddenly, Edward Jones Butler, B.A., M.D., Fleet Surgeon R.N. (retired), second surviving son of the late John Butler, Leinster-square, Rathmines, Dublin, aged 54.

FROST.—On Feb. 3rd, Helena Maria, the dearly beloved wife of John Kingdon Frost, M.R.C.S., and only daughter of F. W. Sutton, Esq., Inspector of Machinery R.N. (retired), aged 29.

GRAY.—On Jan. 2nd, John Temperley Gray, L.R.C.P. Lond., M.R.C.S., of Bombay.

HICKSON.—On Jan. 31st, at Norland-square, London, W., Albert Thomas Hickson, M.A., M.D., sixth son of the late W. M. Hickson, R.M.

JACKSON.—Washed overboard in a gale, John Simpson Matthew Jackson, B.A., Senior Moderator, M.B. T.C.D., L.R.C.S.I., Surgeon ss. *Angola*, eldest son of Sir Robert W. Jackson, Eglinton, Sandymount, Dublin.

MACDONALD.—On Jan. 31st, at Kirkdale, Liverpool, A. D. Macdonald, M.D., C.M. Edin., aged 37.

MUGGERIDGE.—On Jan. 19th, at Balham, Henry Harris Muggeridge, M.R.C.S., LL.D., aged 77.

OWEN.—On Jan. 22nd, at Brecon, Robert Owen, L.R.C.P., L.R.C.S. Edin., aged 39.

PAGET.—On Jan. 29th, at Cambridge, Sir George E. Paget, K.C.B., M.D., F.R.S., Regius Professor of Physic in the University of Cambridge, and Fellow of Gonville and Caius College, aged 83.

STADDON.—On Jan. 29th, at Silent-street, Ipswich, John Hart Staddon, M.R.C.S., L.R.C.P., aged 61.

STURTON.—On Jan. 30th, at Stevenage, Herts, H. W. S. Sturton, M.R.C.S., of Greenwich, second son of the late William Sturton, M.R.C.S., L.S.A., of Croydon.

WARBURTON.—On Jan. 23rd, at his residence, Low Croft House, Wibsey, near Bradford, Yorkshire, Henry Alfred Warburton, M.R.C.S., L.S.A., aged 73 years.

WHITE.—On Jan. 26th, in London, from acute pneumonia, arising from influenza, Samuel Gamble White, Brigade Surgeon, retired, aged 53.

WOLFF.—On Jan. 31st, at Gloucester-gardens, Abraham Wolff, F.R.C.S., aged 73.

N.B.—A fee of 5s. is charged for the Insertion of Notices of Births Marriages, and Deaths.

Medical Diary for the ensuing Week.

Monday, February 8.

ST. BARTHOLOMEW'S HOSPITAL.—Operations, 1.30 P.M., and on Tuesday, Wednesday, Friday, and Saturday at the same hour.

ROYAL LONDON OPHTHALMIC HOSPITAL, MOORFIELDS.—Operations daily at 10 A.M.

ROYAL WESTMINSTER OPHTHALMIC HOSPITAL.—Operations, 1.30 P.M., and each day at the same hour.

CHELSEA HOSPITAL FOR WOMEN.—Operations, 2.30 P.M.; Thursday, 2.30.

HOSPITAL FOR WOMEN, SOHO-SQUARE.—Operations, 2 P.M., and on Thursday at the same hour.

METROPOLITAN FREE HOSPITAL.—Operations, 2 P.M.

ROYAL ORTHOPÆDIC HOSPITAL.—Operations, 2 P.M.

CENTRAL LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M., and each day in the week at the same hour.

UNIVERSITY COLLEGE HOSPITAL.—Ear and Throat Department, 9 A.M.; Thursday, 9 A.M.

LONDON POST-GRADUATE COURSE.—Royal London Ophthalmic Hospital: 1 P.M., Mr. Wm. Lang: Conjunctival Affections.—Great Northern Central Hospital: 8 P.M., Dr. Galloway: Gastro-Intestinal Tract.

MEDICAL SOCIETY OF LONDON.—8.30 P.M. Dr. J. W. Carr: Enlargement of the Spleen in Young Children.—Dr. J. S. Keser: The Treatment of some forms of Chronic Bronchitis by the Water of Weissenburg (Switzerland).

Tuesday, February 9.

KING'S COLLEGE HOSPITAL.—Operations, 2 P.M.; Fridays and Saturdays at the same hour.

GUY'S HOSPITAL.—Operations, 1.30 P.M., and on Friday at same hour. Ophthalmic Operations on Monday at 1.30 and Thursday at 2 P.M.

ST. THOMAS'S HOSPITAL.—Ophthalmic Operations, 4 P.M.; Friday, 2 P.M.

ST. MARK'S HOSPITAL.—Operations, 2 P.M.

CANCER HOSPITAL, BROMPTON.—Operations, 2 P.M.; Saturday, 2 P.M.

WESTMINSTER HOSPITAL.—Operations, 2 P.M.

WEST LONDON HOSPITAL.—Operations, 2.30 P.M.

ST. MARY'S HOSPITAL.—Operations, 1.30 P.M. Consultations, Monday, 2.30 P.M. Skin Department, Monday and Thursday, 9.30 A.M. Throat Department, Tuesdays and Fridays, 1.30 P.M. Electro-therapeutics, same day, 2 P.M.

ROYAL INSTITUTION.—3 P.M. Professor V. Horsley: The Brain.

LONDON POST-GRADUATE COURSE.—Hospital for Skin Diseases, Blackfriars: 4 P.M., Mr. J. Hutchinson: Lichen Planus.—Bethlem Hospital: 2 P.M., Dr. Hyslop: Puerperal and Lactational Insanity.—Charing-cross Medical School: 8 P.M., Dr. Potter: The Sequelæ of Abortion.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.—Mr. Holmes will exhibit a Patient on whom Pirogoff's Amputation was performed twelve years ago.—Dr. Mitchell Bruce and Mr. A. Marmaduke Sheild: Gelatinous Degeneration of Hydatid Cysts.—Dr. Archibald E. Garrod: The Changes in the Blood in the course of Rheumatic Attacks.

Wednesday, February 10.

NATIONAL ORTHOPÆDIC HOSPITAL.—Operations, 10 A.M.

MIDDLESEX HOSPITAL.—Operations, 1.30 P.M.; Saturdays, 2 P.M. Obstetrical Operations, Thursdays, 2 P.M.

CHARING-CROSS HOSTITAL.—Operations, 3 P.M., and on Thursday and Friday at the same hour.

ST. THOMAS'S HOSPITAL.—Operations, 1.30 P.M.; Saturday, same hour.

LONDON HOSPITAL.—Operations, 2 P.M.; Thursday & Saturday, same hour.

ST. PETER'S HOSPITAL, COVENT-GARDEN.—Operations, 2 P.M.

SAMARITAN FREE HOSPITAL FOR WOMEN AND CHILDREN.—Operations, 2.30 P.M.

GREAT NORTHERN CENTRAL HOSPITAL.—Operations, 2 P.M.

UNIVERSITY COLLEGE HOSPITAL.—Operations, 1.30 P.M.; Skin Department, 1.45 P.M.; Saturday, 9.15 A.M.

ROYAL FREE HOSPITAL.—Operations, 2 P.M., and on Saturday.

CHILDREN'S HOSPITAL, GREAT ORMOND-STREET.—Operations, 9.30 A.M. Surgical Visits on Wednesday and Saturday at 9.15 A.M.

LONDON POST-GRADUATE COURSE.—Hospital for Consumption, Brompton: 4 P.M., Dr. Green: Cases in the Wards.—Royal London Ophthalmic Hospital: 8 P.M., Mr. J. B. Lawford: Optic Nerve Atrophy. Parkes Museum: 1 P.M., Dr. Louis C. Parkes: Defective Sanitary Arrangements in Houses, and their Effects upon Health.

Thursday, February 11.

ST. GEORGE'S HOSPITAL.—Operations, 1 P.M. Surgical Consultations Wednesday, 1.30 P.M. Ophthalmic Operations, Friday, 1.30 P.M.

UNIVERSITY COLLEGE HOSPITAL.—Operations, 2 P.M.; Ear and Throat Department, 9 A.M.

ROYAL INSTITUTION.—3 P.M. Professor E. Ray Lankester: Some Recent Biological Discoveries.

LONDON POST-GRADUATE COURSE.—Hospital for Sick Children, Great Ormond-st.: 4 P.M., Dr. Barlow: Illustrations of Abdominal Disease in Children.—National Hospital for the Paralysed and Epileptic: 2 P.M., Dr. Buzzard: Cases in the Hospital.—London Throat Hospital, Gt. Portland-st.: 8 P.M. Dr. Woakes: Necrosing Ethmoiditis.

NORTH LONDON MEDICAL AND CHIRURGICAL SOCIETY (Great Northern Central Hospital).—9 P.M. Dr. Lewis Jones: Electricity as an Aid to Medical and Surgical Diagnosis and Treatment.

BRITISH GYNÆCOLOGICAL SOCIETY.—8.30 P.M. Specimens will be shown by Dr. Granville Bantock. Dr. Heywood Smith: Subperitoneal Hysterectomy.

Friday, February 12.

ROYAL SOUTH LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M.

LONDON POST-GRADUATE COURSE.—Hospital for Consumption, Brompton: 4 P.M., Dr. Green: Cases in the Wards.—Bacteriological Laboratory, King's College: 11 A.M. to 1 P.M., Professor Crookshank: Tuberculosis (Examination of Sputum, &c.).—Charing-cross Medical School: 8 P.M., Dr. Potter: The Uterine Sound.

CLINICAL SOCIETY OF LONDON.—Dr. Lees: Three cases of Perforation of the Vermiform Appendix.—Mr. Page: (1) A case of Acute Appendicites, Removal of Appendix, Recovery; (2) A case of Relapsing Appendicites, Operation, Recovery.—Mr. Stephen Paget: An unusual case of Sloughing of the Vermiform Appendix.—Mr. Bland Sutton: A case of Cholelithiasis, Removal of Impacted Gall-stones through an Incision in the Common Duct; Recovery.

ROYAL INSTITUTION.—9 P.M. Mr. G. J. Symonds: Rain, Snow, and Hail.

Saturday, February 13.

UNIVERSITY COLLEGE HOSPITAL.—Operations, 2 P.M.; and Skin Department 9.15 A.M.

LONDON POST-GRADUATE COURSE.—Bethlem Hospital: 11 A.M., Dr. Hyslop; Climacteric Insanity.

ROYAL INSTITUTION.—3 P.M. Right Hon. Lord Rayleigh: Matter, at Rest and in Motion.

METEOROLOGICAL READINGS.

(Taken daily at 8.30 a.m. by Steward's Instruments.)

THE LANCET Office, Feb. 4th, 1892.

Date.	Barometer reduced to Sea Level and 32° F.	Direction of Wind.	Dry Bulb.	Wet Bulb.	Solar Radiation in Vacuo.	Maximum Temp. Shade.	Min. Temp	Rainfall.	Remarks at 8.30 A.M.
Jan. 29	30·07	W.	51	49	54	51	39	...	Cloudy
,, 30	30·19	W.	49	46	67	54	46	...	Cloudy
,, 31	30·18	W.	49	49	62	52	48	·08	Raining
Feb. 1	29·68	S.W.	48	46	51	48	46	·01	Overcast.
,, 2	29·32	W.	39	36	73	45	36	·04	Cloudy
,, 3	29·25	N.W.	41	39	65	46	37	·14	Cloudy
,, 4	29·75	S.W.	34	33	64	43	34	..	Overcast.

Notes, Short Comments, & Answers to Correspondents.

It is especially requested that early intelligence of local events having a medical interest, or which it is desirable to bring under the notice of the profession, may be sent direct to this Office.

All communications relating to the editorial business of the journal must be addressed "To the Editors."

Lectures, original articles, and reports should be written on one side only of the paper.

Letters, whether intended for insertion or for private information, must be authenticated by the names and addresses of their writers, not necessarily for publication.

We cannot prescribe or recommend practitioners.

Local papers containing reports or news paragraphs should be marked and addressed "To the Sub-Editor."

Letters relating to the publication, sale, and advertising departments of THE LANCET to be addressed "To the Publisher."

We cannot undertake to return MSS. not used.

WINE COMPANIES AND MEDICAL ADVERTISEMENTS.

Dr. J. Fletcher Little directs our attention to the objectionable way in which the medical virtues of a certain wine are described in a very widely circulated pamphlet. We agree with him. It is surely possible to advertise a wine without entering into all the details of chlorosis, the mysterious joys of maternity, &c. Such a parade of questionable learning is not likely to conciliate the medical profession.

O'DWYER'S TUBES.

To the Editors of THE LANCET.

SIR,—Having read in your issue of Jan. 23rd Dr. Sutherland's excellent report of a case in which a twice-saved life was ultimately lost from the slipping of an intubation tube into a bronchus, I have noticed that the tube is described as being of size No. 3, two inches and a quarter long. This size is the largest in the sets of intubation tubes usually sold, and at the time of the accident was, I believe, the largest in vogue in England. Dr. O'Dwyer intends this size for children of from ten to twelve years of age. For adults he used much larger vulcanite tubes, or, in cases of narrow stricture, tubes with much wider heads. Messrs. Weiss of Oxford-street have promised to copy O'Dwyer's vulcanite tubes for adults. The case may prejudice the prospects of intubation, unless it be borne in mind that such an accident, unavoidable last March, cannot occur in treatment with the more recent tubes.—I am, Sirs, faithfully yours,

HORACE COLLIER, F.R.C.S.

Children's Hospital, Great Ormond-street, Feb. 2nd, 1892.

NEW SPINAL JACKET.

DR. J. MARSHALL HAWKES describes in the *Philadelphia Medical News* a new kind of jacket which he has successfully used in a spinal case, to the great relief of the patient. It consisted of pure jute fibre free from clay and wood pulp; and from its very light weight, its imperviousness to moisture, and the efficient support which it gave it was found to be much more satisfactory than plaster. A model of the patient's body was made by winding wet plaster bandages round her from the anterior superior spinous processes of the ilia to the lower axillary borders. A plaster caste made from this mould was modelled so as to preserve the natural anatomical contour of the patient, and on this cast the paper, cut into strips half an inch wide, was laid in successive layers. It was then divided down each axillary line and laced with elastic, thus allowing of some expansion during respiration. The total weight of such a jacket is only about twelve ounces, and its advantages over the cumbrous plaster apparatus are obvious. Dr. Hawkes has also made splints in a similar way, and has found them to be very convenient and thoroughly efficient.

Mr. Mayo Robson (Leeds).—The paper will appear next week.

Snowdrop should consult his medical adviser.

POSTAGE STAMPS AND INFECTION.

To the Editors of THE LANCET.

SIRS,—As any hypothesis regarding the spread of influenza may be suggestive, I venture to offer one that I have not seen noticed before.

During the first epidemic the Post-office officials seemed to be among the first affected both in this country and abroad, and one of the first cases reported in England was in the Foreign Office, when Lord Salisbury was attacked. May it not be that in these cases the source of infection was the saliva used to moisten the gummed surface of stamps and edges of envelopes, the mucilage perhaps being a suitable menstruum for the development of bacilli? In trying to follow up the probability of this theory I have been struck by the number of instances in which patients attribute an attack to a letter received from an infected house or district. Of course, this, if a source, can be only one of many, yet one that can easily be destroyed, hence worth attention.

I am, Sirs, yours truly,

Feb. 1st, 1892. H. L. G.

DR. COLLIE.

To the Editors of THE LANCET.

SIRS,—To-day our much-esteemed colleague has quitted the scene of his twenty-one years' arduous and risky labours. He was not permitted to depart without a warm expression of affectionate regard from all who had the pleasure of serving under him in the Eastern Hospital. A meeting was held, and a testimonial presented, which had been subscribed for by the staff of *employés* as a small recognition of the high esteem in which he was held, and their warm appreciation of his long and faithful services. Dr. Collie (who was much affected) briefly returned thanks, and the meeting separated. Now it occurs to me that the present would be a suitable opportunity for the profession to testify by a substantial testimonial its sense of Dr. Collie's high personal worth and professional attainments. If THE LANCET would give its powerful influence to forward that object, I doubt not the response would be a warm one.

I am, Sirs, your obedient servant,

Jan. 29th, 1892. M.D., L.R.C.P. LOND.

A DANGER IN DOUCHING.

To the Editors of THE LANCET.

SIRS,—A point worth remembering when douching the abdominal cavity after ovariotomy &c. is that the water, though poured into receptacle a moment before out of a boiling kettle will, when allowed to flow from end of rubber tube, be found almost quite cold for about ten seconds, the heat being abstracted by the length of tubing (generally six feet or so) before exit. I only discovered this quite accidentally on a patient exclaiming how cold the water was while douching the vagina, when I had a moment before almost filled the receptacle from the boiling kettle, and added cold water to make it a bearable heat. As I have not heard or seen notice of this fact I think it worth while drawing attention to it, as the shock of a cold stream of water turned on the abdominal viscera, under the impression that the water was hot, might make all the difference in the subsequent result of an operation.

I am, Sirs, yours faithfully,

Dublin. ALEXANDER DUKE.

"THE MIASMATIC THEORY OF ACUTE RHEUMATISM."

To the Editors of THE LANCET.

SIRS,—Please allow me to correct an unfortunate error which crept into my letter to THE LANCET last week—viz., the attribution of the miasmatic theory of acute rheumatism and the salicin treatment to Sir D. Maclagan, instead of to Dr. T. J. Maclagan, of 9, Cadogan-place, London. I regret the mistake, and hasten to have it rectified. Dr. Maclagan is deserving of all the honour which his professional brethren can give; for who can estimate the full extent of the relief which he has afforded to suffering humanity by suggesting the use of salicin in acute rheumatism?—I am, Sirs, yours faithfully,

Harrogate, Feb. 3rd, 1892. J. GORDON BLACK.

CATARACT COMPLICATED WITH GRAVES' DISEASE.

DR. S. N. LOSHECHNIKOFF publishes in a recent number of the *St. Petersborger Medicinische Wochenschrift* a case of cataract, which he had extracted in a patient aged twenty who was the subject of Graves' disease. There was soft cataract in both eyes, with considerable exophthalmos. Pulse 110. The urine contained neither albumen nor sugar. Six convulsive seizures had taken place before the sight appeared affected. The author extracted the left cataract upwards, having been able to save the sphincter iridis in the iridectomy. The lens was easily pressed out. The iris was replaced in a good position, but the margins of the corneal wound remained patent. The wound was washed with sublimate, and eserine applied before the dressing. When the latter was changed, three days afterwards, the chamber was found of good depth, but there were hyphæma and œdema of the conjunctiva, and the patient complained of pain. The margins of the wound were in good apposition. Three days later the hyphæma and œdema were less, but the former had increased again in another three days, and the colour of the iris had lost its clearness. Pulse 98. A week later, subacute iritis came on, which ran a course of four weeks. Double iridectomy was then performed, there being a slight fissure and a little loss of vitreous. Three days later the cornea had become opaque, and all dressing was then discontinued. The iris had become transparent in ten days, but was covered by opaque cornea. Fowler's solution was administered, but the patient did not bear it well, and the pulse had risen to 100. Digitalis was substituted and iridectomy performed for a second time, with an ultimate result of V. $\frac{1}{10}$.

Mr. R. E. Johnson might consult with advantage the tariff of charges published by the Manchester Medico-Ethical Association.

Dreamer.—Dr. Hack Tuke: "Sleep-walking and Hypnotism," 1884.

A CORRECTION.

To the Editors of THE LANCET.

SIRS,—I shall esteem it a favour if you will allow me through your columns to correct a mistake in my address, which occurs in the Medical Directory for 1892, on page 931. My address is there given as 11, Palatine-street, Harpurhey, whereas it should be, as it has been for some years past, 14, St. John-street and 3, Stanley-grove, Oxford-road. I should not have troubled you in this matter but that several important letters and telegrams have already been sent to the wrong address by members of the profession; and to obviate such mistakes in future I would ask those who have the Directory for 1892 to make the necessary correction.

I am, Sirs, yours faithfully,

Manchester, Feb. 2nd, 1892. JAMES ROSS, M.D., F.R.C.P. Lond.

"INFLUENZA ROBBED OF ITS TERRORS" IN LIVERPOOL.

Medicus is naturally indignant at a vulgar handbill vaunting the powers of a remedy called "Antigrippe," "Bloodsteriliser," and other powerful names, the more so as he is assured that it is the work of a qualified medical man. We advise our correspondent to be sceptical on this point.

Eyeball.—Ophthalmology: Nettleship, Lawson, Berry, Juler. Diseases of Children: Ashby and Wright, Eustace Smith, Goodhart.

Dr. R. J. Shepherd (Pau).—The paper will appear shortly.

COUCHAIDE.

To the Editors of THE LANCET.

SIRS,—Will any good brother who may have had experience of Dr. Diver's "couchaide," figured in Messrs. Down Bros.' catalogue, p. 505, kindly say how far it meets with approval, and if any precaution is necessary in its use? I have long used a firm-fitting binder when labour commences, to be readjusted from time to time, and additional support with the hand or towel during the severer pains. But the comments of experienced accoucheurs on this contrivance will be gratefully received by Yours most truly,

January 31st, 1892. F.R.C.S.

Spes.—Our correspondent will see from an announcement in another column that the name will probably be changed to "Gresham."

Dr. Campbell (Garlands).—Yes, very soon.

THE HODGSON FUND.

To the Editors of THE LANCET.

SIRS,—Please acknowledge the following amount for the above fund.

Mr. C. J. Stocker, Forest gate, £1 1*s.*

I am, Sirs, faithfully yours,

J. PHILLIP TOPPING.

271, Romford-road, Forest-gate, Feb. 3rd, 1892.

ERRATUM.—In Mr. Jessett's letter on "A Suggestion for the Treatment of Irreducible Intussusception of the Bowels," which appeared in our issue of Jan. 23rd, twenty-three lines from the bottom of the page, the following sentence occurs: "Even if this should not be the case, three or four quill sutures, &c." It should be "three or four *quilt* sutures."

COMMUNICATIONS not noticed in our present issue will receive attention in our next.

COMMUNICATIONS, LETTERS, &c., have been received from—Messrs. Allen and Hanburys, London; Surgeon-Chaplain Addison, Netley; Mr. H. C. Amor, Newport; Mr. Bottomley, Ashton-under-Lyne; Messrs. Battle and Co., Paris; M. Berthier, Paris; Messrs. Burgoyne Burbidges, and Co. London; Dr. Brock, London; Dr. Barbour; Messrs. Barker and Sons, London; Mr. Brown, Brinmore; Dr. Blomfield, Exeter; Mr. J. Briscoe, Leeds; Messrs. Blondeau et Cie., London; Messrs. Bailey and Son, London; Dr. H. B. Collins, London; Mr. Coulson, South Shields; Dr. Crook, Margate; Mr. Clutton, London; Messrs. Clay and Sons, London; Mr. Coghill, Birmingham; Messrs. J. Cleave and Son, Crediton; Dr. T. Clark, London; Messrs. Chalmers, Wade, and Co., Liverpool; Mr. Crook, Chudleigh; Dr. Court; Mr. H. Collier, London; Dr. Cochrane, Longford; Mr. Cooper, Bristol; Dr. Campbell, Garlands; Sir Francis De Winton, Windsor; Mr. Davies, North Walsham; Mr. A. Doran, Dublin; Miss Docwra; Messrs. Duke and Gorcham, London; Mr. Davis, Ivybridge; Mr. Duke, Dublin; Dr. De Jersey, London; Mrs. Everard; Mr. Frost, London; Mr. Gillespie, Derby; Dr. Gwynn, Hampstead; Professor Godwin, Netley; Mr. C. Goslett; Dr. H. L. Gordon, Witheridge; Mr. Hornibrook, London; Dr. Hedley, Brighton; Dr. Haycraft, Edinburgh; Mr. Hearnden, Leatherhead; Messrs. Humphreys, London; Dr. C. F. Hutchinson, Monte Carlo; Messrs. Isaacs and Co., London; Messrs. Jensen and Co., London; Dr. Joynt, Bradford; Mr. Jessett, London; Mr. Kestin, London; Dr. Kelyneck, Manchester; Messrs. Kegan Paul and Co., London; Dr. F. Little, London; Mr. Leggott; Mr. Little, London; Dr. Merryweather, Guisborough; M. Mareschal, Paris; Mr. Michelli, London; Dr. McMordie, Belfast; Mr. Martindale, London; Dr. C. F Moore, Dublin; Mr. Macintosh, London; Messrs. Marris and Cooke, Grimsby; Dr. J. Oliver, London; Messrs. Oppenheimer, Sons, and Co., London; Dr. Oberlaender, Dresden; Mr. O'Reilly, Highgate; Mr. Parkhurst, London; Dr. Philip, Belfast; Miss Pudney, Earl's Colne; Dr. Paterson, Stockton-on-Tees; Mr. Pentland, Ediuburgh; Mr. Mayo Robson, Leeds; Dr. Ross, Manchester; Mr. Rouse, New Southgate; Mr. Rose, London; Dr. Strechan, Lavenham; Mr. Noble Smith, London; Dr. G. Steell, Manchester; Mr. Swanwich, West Hartlepool; Mr. Sharpe, Matlock; Dr. A. B. Stevens; Messrs. G. and G. Stern, London; Dr. F. J. Smith, London; Messrs. Street and Co., London; Mr. Sullivan, Dublin; Dr. Shepherd, Pau; Dr. J. E. Squire, London; Dr. W. R. Smith, London; Professor Anderson Stuart, Sydney; Mr. Stenhouse, Glasgow; Messrs. Smith and Co., London; Dr. Serphioti, Galatz; Dr. Thomson, Norwich; Dr. D. Turner, Edinburgh; Dr. A. Thomson, Painswick; Dr. Voigt, Southport; Mr. Vickers, London; Mr. Ward, Derby; Messrs. W. Wood and Co., New York; Dr. Walthard, Berlin; Mr. Wilson, Dumfries; Dr. Whitelaw; Mr. Waller, Stroud; Dr. Wortabet, Beyrout; Mr. Walsham, London; Mr. Zimmerman, London; Cyclops; A Bacillied Bard; M.D., L.R.C.P.L.; Snowdrop; Medicus; Spes; South London Paper Stock Co.; C. H. S., London; Bachelor, London; Metropolitan Machinists Co., London; Certainty, London; Secretary, Gloucester General Infirmary; W. J. P.; F.R.C.S.; Dreamer; H. L. G.; Crux, Cardiff; L.R.C.P., L.R.C.S.; Quinine, London; Secretary, General Hospital, Birmingham; Matron, Manchester.

LETTERS, *each with enclosure*, are also acknowledged from—Mr. De la Rue, London; Mr. Tyte, Minchinhampton; Messrs. Whitworth and Stewart, Manchester; Mr. Breach, Newbury; Messrs. Catherall and Co., Hexham; Dr. Maskew, Southampton; Mr. Moriarty, Wickham Market; Dr. Junker, Robe; Mr. Twyford, Hanley; Messrs. Curry and Paxton, London; Mr. Bateman, Exbourne; Messrs. Collins and Collins, Wanstead; Mr. Paterson, Stockton-on-Tees; Messrs. Keith and Co., Edinburgh; Mr. Brockelbank, Islington; Messrs. Jarrold and Son, Norwich; Mr. Meyram, Pittsburg; Messrs. Powneeby and Co., London; Mr. Bigg, London; Mr. Orr, Farnham; Messrs. Vinton and Co., London; Rev. Mr. Morrison, co. Durham; Messrs. Oliver and Boyd, Edinburgh; Dr. Smith, Cornwall; Mr. Patterson, Fence Houses; Mr. Webb, Devon; Mr. Hind, Jersey; Messrs. Potter and Sacker, London; Mr. Gardiner, Shrewsbury; Messrs. Slinger and Son, York; Mr. Mabey, Devon; Mr. Hawkins, Nice; Messrs. Kilner Bros., London; Dr. Lee, Oxon; Mr. Orme, Leigh; Messrs. Hooper and Co., London; Lord Templetown, co. Antrim; Messrs. Porteous and Co., Glasgow; Rev. Mr. Beedham, Cambridge; Messrs. Back and Co., London; Mr. Wand, Leicester; Mr. Sargent, London; Mr. Klug, Paris; Mr. Roberts, Twyford; Dr. Holmes, Southam; Mr. Anderson, Carmarthen; Mr. Fawsett, Lewes; Dr. Osburne, Hythe; Mr. E. H. Peach, London; Mr. McMurtrie, Glasgow; Mr. Barnicot, Huddersfield; Miss Walker, London; Mr. Rowlands, Merioneth; Dr. Sykes, Barnsley; Mr. Drummond, Bristol; Mr. Wright, Bradford; Mr. Owen, Fishguard; Mr. Williams, Bootle; Mr. Calder, Redland; Mr. Vokes, Birmingham; Dr. Williams, Talgarth; Mr. Roberts, Nettlebed; Mr. Hanly, Ormskirk; Mr. Webster, Bradford; Mr. Bigland, Liverpool; Mr. Johnson, Leicester; Mr. McMordie, Belfast; Mr. Leach, Kensington; Mr. Brice, Bridgewater; Mr. Frost, Frome; Drs. Fenn and Blight, Diss; Mr. Heywood, Manchester; Mr. Nicholls, Bury St. Edmunds; Miss McDonnell, Belfast; Dr. Moorhead, Hucknall Torkard; Dr. Boreham, Torquay; Mr. Hoare, Farnham; Mr. King, Guildford; Mr. Fiske, Okehampton; Dr. Marston, Wood-green; Dr. Murphy, Newport; Mr. Clowes, Colchester; Mr. Ballackey, Chelford; A. H. E., London; M.A., Rugby; Julian, London; 228, Kentish Town-road; Medicus, Bradford; W. B., Bridgwater; Dr. A., South Hackney; Graduate, London; Medicus, Manchester; Sarah Acland Home, Oxford; Surgeon, Huddersfield; Secretary, Blackburn and East Lancs Infirmary; L.R.C.P., London; Jeyes' Sanitary Compound Co., London; Medicus, Bradford; H. O., London; Secretary, Durham County Hospital; Vernon, Sheffield; Secretary, Royal Albert Edward Infirmary, Wigan; Medicus, Wednesbury; Maltine Manufacturing Co., Bloomsbury; E. D., Stow-on-the-Wold; Secretary, Royal Albert Hospital, Devonport; X., London; W., London; Secretary, Radcliffe Infirmary; M.R.C.S., London; 82, Alvey-street, Walworth; Class Rooms, Edinburgh; F. W. A., London; E. B., London; Physician, London; Medical, London; Kudos, London; Alpha, London; M.B., Bournemouth; Urbanus, London; Melbourne, London; G. E. D., London; H. G., London; Cortex, London; Ruthin, London; A. B. C., London; W. S. H., London; Cymro, London; Esse, London; Dr. S London; Surrey, London; C. M. A., London; Centum, London; Surgeon, London; Medicus, London.

NEWSPAPERS.—*Derbyshire Advertiser, West Cumberland Times, Liverpool Courier, Scotsman, Manchester Guardian, Sussex Daily News, Bradford Observer, Yorkshire Herald, Western Mail, Blackburn Times, Birmingham Post, Insurance Record, City Press, Port Elizabeth Telegraph and Eastern Province Standard (South Africa), Local Government Chronicle, Leeds Mercury, Hertfordshire Mercury, Royal Cornwall Gazette, Yorkshire Post, Bristol Mercury, Builder, Architect, Pullen's Kent Argus, Leicester Daily Post, The Advertiser (Adelaide), Essex County Chronicle, The Observer, West Middlesex Advertiser, The Cape Times, Metropolitan, Le Temps (Paris), Folkestone Herald, Times of India, Court Circular, Daily Graphic, Bury Guardian, Pioneer Mail, Daily Express (Dublin), Bath Herald, Somerset County Gazette, Manchester Examiner, Devon Daily Gazette, Scottish Leader, The Policy-Holder (Manchester), Reading Mercury, Surrey Advertiser, The Daily Inter-Ocean (Chicago), Scarborough Evening News, The Verulam Review, Oracle, &c.*, have been received.

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